House of Representatives

General Assembly

File No. 351

January Session, 2021

Substitute House Bill No. 6626

House of Representatives, April 8, 2021

The Committee on Insurance and Real Estate reported through REP. WOOD, K. of the 29th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING REQUIRED HEALTH INSURANCE AND MEDICAID COVERAGE, AMBULANCE SERVICES AND COST TRANSPARENCY.

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

Section 1. (NEW) (*Effective January 1, 2022*) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, shall provide coverage for: (1) Motorized wheelchairs, including, but not limited to, used motorized wheelchairs; (2) repairs to motorized wheelchairs; and (3) replacement batteries for motorized wheelchairs.

Sec. 2. (NEW) (*Effective January 1, 2022*) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, shall provide coverage for: (1) Motorized

wheelchairs, including, but not limited to, used motorized wheelchairs; (2) repairs to motorized wheelchairs; and (3) replacement batteries for motorized wheelchairs.

Sec. 3. (NEW) (*Effective January 1, 2022*) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, shall provide coverage for: (1) A unilateral cochlear implant, and unilateral cochlear implant surgery, for an insured who has been diagnosed with unilateral hearing loss; and (2) bilateral cochlear implants, and bilateral cochlear implant surgery, for an insured who has been diagnosed with bilateral hearing loss.

Sec. 4. (NEW) (*Effective January 1, 2022*) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, shall provide coverage for: (1) A unilateral cochlear implant, and unilateral cochlear implant surgery, for an insured who has been diagnosed with unilateral hearing loss; and (2) bilateral cochlear implants, and bilateral cochlear implant surgery, for an insured who has been diagnosed with bilateral hearing loss.

Sec. 5. (NEW) (*Effective January 1, 2022*) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, shall provide coverage for medically necessary coronary calcium scan tests.

Sec. 6. (NEW) (*Effective January 1, 2022*) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, shall provide coverage for medically necessary coronary calcium scan tests.

Sec. 7. (NEW) (*Effective January 1, 2022*) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, shall provide coverage for genetic cystic fibrosis screenings for women.

Sec. 8. (NEW) (*Effective January 1, 2022*) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, shall provide coverage for genetic cystic fibrosis screenings for women.

Sec. 9. (NEW) (*Effective January 1, 2022*) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, shall provide coverage for the treatment of neurological conditions and diseases, including, but not limited to, physical therapy for the treatment of amyotrophic lateral sclerosis.

Sec. 10. (NEW) (*Effective January 1, 2022*) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, shall provide coverage for the treatment of neurological conditions and diseases, including, but not limited to, physical therapy for the treatment of amyotrophic lateral sclerosis.

Sec. 11. (NEW) (*Effective January 1, 2022*) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, shall provide coverage for equine therapy for an insured who is a veteran. For the purposes of this section,

"veteran" has the same meaning as provided in section 27-103 of the general statutes.

Sec. 12. (NEW) (*Effective January 1, 2022*) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, shall provide coverage for equine therapy for an insured who is a veteran. For the purposes of this section, "veteran" has the same meaning as provided in section 27-103 of the general statutes.

Sec. 13. (NEW) (*Effective January 1, 2022*) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, shall provide coverage for gambling disorder treatment. For the purposes of this section, "gambling disorder" has the same meaning as provided in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

Sec. 14. (NEW) (*Effective January 1, 2022*) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, shall provide coverage for gambling disorder treatment. For the purposes of this section, "gambling disorder" has the same meaning as provided in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

Sec. 15. (NEW) (*Effective January 1, 2022*) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, shall provide coverage for audiologic, ophthalmologic and optometric care.

Sec. 16. (NEW) (*Effective January 1, 2022*) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, shall provide coverage for audiologic, ophthalmologic and optometric care.

Sec. 17. (NEW) (*Effective July 1, 2021*) (a) The Commissioner of Social Services shall provide Medicaid reimbursement for audiologic, ophthalmologic and optometric care.

(b) The commissioner shall seek federal approval of a Medicaid state plan amendment or Medicaid waiver, if necessary, to implement the provisions of this section. Any submission of a Medicaid state plan amendment or Medicaid waiver shall be in accordance with the provisions of section 17b-8 of the general statutes.

(c) The commissioner shall adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of this section. The commissioner may adopt policies or procedures to implement the provisions of this section while in the process of adopting regulations, provided such policies or procedures are posted on the Internet web site of the Department of Social Services and on the eRegulations System prior to the adoption of such policies or procedures.

Sec. 18. Section 38a-492c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) For purposes of this section:

(1) "Inherited metabolic disease" includes (A) a disease for which newborn screening is required under section 19a-55; and (B) cystic fibrosis.

(2) "Low protein modified food product" means a product formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction

of a physician.

(3) "Amino acid modified preparation" means a product intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.

(4) "Specialized formula" means a nutritional formula **[**for children up to age twelve**]** that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal Food and Drug Administration and is intended for use solely under medical supervision in the dietary management of specific diseases.

(b) 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, renewed, amended or continued in this state shall provide coverage for amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases if the amino acid modified preparations or low protein modified food products are prescribed for the therapeutic treatment of inherited metabolic diseases and are administered under the direction of a physician.

(c) 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, renewed, amended or continued in this state shall provide coverage for specialized formulas when such specialized formulas are medically necessary for the treatment of a disease or condition and are administered under the direction of a physician.

(d) Such policy shall provide coverage for such preparations, food products and formulas on the same basis as outpatient prescription drugs.

Sec. 19. Section 38a-518c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) For purposes of this section:

(1) "Inherited metabolic disease" includes (A) a disease for which newborn screening is required under section 19a-55; and (B) cystic fibrosis.

(2) "Low protein modified food product" means a product formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.

(3) "Amino acid modified preparation" means a product intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.

(4) "Specialized formula" means a nutritional formula **[**for children up to age twelve**]** that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal Food and Drug Administration and is intended for use solely under medical supervision in the dietary management of specific diseases.

(b) 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, renewed, amended or continued in this state shall provide coverage for amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases if the amino acid modified preparations or low protein modified food products are prescribed for the therapeutic treatment of inherited metabolic diseases and are administered under the direction of a physician.

(c) 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, renewed, amended or continued in this state shall provide coverage for specialized formulas when such specialized formulas are medically necessary for the treatment of a

disease or condition and are administered under the direction of a physician.

(d) Such policy shall provide coverage for such preparations, food products and formulas on the same basis as outpatient prescription drugs.

Sec. 20. Section 38a-492k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) 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, amended, renewed or continued in this state shall provide coverage for colorectal cancer screening and diagnosis, including, but not limited to, (1) an annual fecal occult blood test, and (2) colonoscopy, flexible sigmoidoscopy or radiologic imaging, in accordance with the recommendations established by the American Cancer Society, based on the ages, family histories and frequencies provided in the recommendations. Except as specified in subsection (b) of this section, benefits under this section shall be subject to the same terms and conditions applicable to all other benefits under such policies.

(b) No such policy shall impose:

(1) A deductible for a procedure that a physician initially undertakes as a screening or diagnostic colonoscopy or **[**a screening**]** sigmoidoscopy; or

(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-493.

Sec. 21. Section 38a-518k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) 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, amended, renewed or continued in this state shall provide coverage for colorectal cancer screening and diagnosis, including, but not limited to, (1) an annual fecal occult blood test, and (2) colonoscopy, flexible sigmoidoscopy or radiologic imaging, in accordance with the recommendations established by the American Cancer Society, based on the ages, family histories and frequencies provided in the recommendations. Except as specified in subsection (b) of this section, benefits under this section shall be subject to the same terms and conditions applicable to all other benefits under such policies.

(b) No such policy shall impose:

(1) A deductible for a procedure that a physician initially undertakes as a screening or diagnostic colonoscopy or **[**a screening**]** sigmoidoscopy; or

(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.

Sec. 22. Section 38a-498 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) (1) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6), (10),**]** (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for medically necessary ambulance services for persons covered by the policy at an in-network level, including an in-network level of cost-sharing. The hospital policy shall be primary if a person is covered under more than one policy. The policy shall, as a minimum requirement, cover such services whenever any person covered by the contract is transported, when medically necessary, by ambulance: **[**to**]**

(A) To a hospital; **[**. Such**]** or

(B) From a hospital to such person's place of residence.

(2) Except as otherwise provided in this section, the benefits required under this section shall be subject to any policy provision which applies to other services covered by **[**such**]** the policies that are subject to this section. Notwithstanding any other provision of this section, such policies shall not be required to provide benefits in excess of the maximum allowable rate established by the Department of Public Health in accordance with section 19a-177.

(b) (1) Each such individual health insurance policy shall provide that any payment by such company, corporation or center for emergency ambulance services under coverage required by this section shall be paid directly to the ambulance provider rendering such service if such provider has complied with the provisions of this subsection and has not received payment for such service from any other source.

(2) Any ambulance provider submitting a bill for direct payment pursuant to this section shall **[**stamp the following statement on the face of each bill: "NOTICE: This bill subject to mandatory assignment pursuant to Connecticut general statutes".**]** indicate that such bill is subject to assignment by:

(A) Stamping such indication on such bill if such bill is submitted on paper; or

(B) Including such indication in such bill if such bill is submitted by electronic means.

(3) This subsection shall not apply to any transaction between an ambulance provider and an insurance company, hospital service corporation, medical service corporation, health care center or other entity if the parties have entered into a contract providing for direct payment.

Sec. 23. Section 38a-525 of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) (1) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6),**]** (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for medically necessary ambulance services for persons covered by the policy at an in-network level, including an in-network level of cost-sharing. The hospital policy shall be primary if a person is covered under more than one policy. The policy shall, as a minimum requirement, cover such services whenever any person covered by the contract is transported, when medically necessary, by ambulance: **[**to**]**

(A) To a hospital; **[**. Such**]** or

(B) From a hospital to such person's place of residence.

(2) Except as otherwise provided in this section, the benefits required under this section shall be subject to any policy provision which applies to other services covered by **[**such**]** the policies that are subject to this section. Notwithstanding any other provision of this section, such policies shall not be required to provide benefits in excess of the maximum allowable rate established by the Department of Public Health in accordance with section 19a-177.

(b) (1) Each such group health insurance policy shall provide that any payment by such company, corporation or center for emergency ambulance services under coverage required by this section shall be paid directly to the ambulance provider rendering such service if such provider has complied with the provisions of this subsection and has not received payment for such service from any other source.

(2) Any ambulance provider submitting a bill for direct payment pursuant to this section shall **[**stamp the following statement on the face of each bill: "NOTICE: This bill subject to mandatory assignment pursuant to Connecticut general statutes".**]** indicate that such bill is subject to assignment by:

(A) Stamping such indication on such bill if such bill is submitted on paper; or

(B) Including such indication in such bill if such bill is submitted by electronic means.

(3) This subsection shall not apply to any transaction between an ambulance provider and an insurance company, hospital service corporation, medical service corporation, health care center or other entity if the parties have entered into a contract providing for direct payment.

Sec. 24. (NEW) (*Effective October 1, 2021*) Not later than January 1, 2022, the Insurance Commissioner shall, within available appropriations, establish a program to advance breast health and breast cancer awareness, and promote greater understanding of the importance of early breast cancer detection, in this state. As part of the program, the commissioner shall, at a minimum, provide outreach to individuals, including, but not limited to, young women of color, in this state regarding the importance of breast health and early breast cancer detection.

Sec. 25. Section 38a-503 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) For purposes of this section:

(1) "Healthcare Common Procedure Coding System" or "HCPCS" means the billing codes used by Medicare and overseen by the federal Centers for Medicare and Medicaid Services that are based on the current procedural technology codes developed by the American Medical Association; and

(2) "Mammogram" means mammographic examination or breast tomosynthesis, including, but not limited to, a procedure with a HCPCS code of 77051, 77052, 77055, 77056, 77057, 77063, 77065, 77066, 77067, G0202, G0204, G0206 or G0279, or any subsequent corresponding code.

(b) (1) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for diagnostic and screening mammograms [to any woman covered under the policy] for insureds that are at least equal to the following minimum requirements:

(A) A baseline mammogram, which may be provided by breast tomosynthesis at the option of the [woman covered under the policy] insured, for [any woman] an insured who is: [thirty-five]

(i) Thirty-five to thirty-nine years of age, inclusive; [and] or

(ii) Younger than thirty-five years of age if the insured is believed to be at increased risk for breast cancer due to:

(I) A family history of breast cancer;

(II) Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene variant that materially increases the insured's risk for breast cancer;

(III) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

(V) Other indications as determined by the insured's physician or advanced practice registered nurse; and

(B) [a mammogram] Mammograms, which may be provided by breast tomosynthesis at the option of the [woman covered under the policy] insured, every year for [any woman] an insured who is: [forty]

(i) Forty years of age or older; [.] or

(ii) Younger than forty years of age if the insured is believed to be at

increased risk for breast cancer due to:

(I) A family history, or prior personal history, of breast cancer;

(II) Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the insured's risk for breast cancer;

(III) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

(V) Other indications as determined by the insured's physician or advanced practice registered nurse.

(2) Such policy shall provide additional benefits for:

(A) Comprehensive **[**ultrasound screening**]** diagnostic and screening ultrasounds of an entire breast or breasts if:

(i) A mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or

(ii) **[**a woman**]** An insured is believed to be at increased risk for breast cancer due to:

(I) A family history, or prior personal history, of breast cancer; **[**,**]**

(II) **[**positive**]** Positive genetic testing **[**, or**]** for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the insured's risk for breast cancer;

(III) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

[(III) other**]** (V) Other indications as determined by **[**a woman's**]** the insured's physician or advanced practice registered nurse; **[**or (iii) such screening is recommended by a woman's treating physician for a woman who (I) is forty years of age or older, (II) has a family history or prior personal history of breast cancer, or (III) has a prior personal history of breast disease diagnosed through biopsy as benign; and**]**

(B) **[**Magnetic**]** Diagnostic and screening magnetic resonance imaging of an entire breast or breasts: **[**in**]**

(i) In accordance with guidelines established by the American Cancer Society **[**.**]** for an insured who is thirty-five years of age or older; or

(ii) If an insured is younger than thirty-five years of age and believed to be at increased risk for breast cancer due to:

(I) A family history, or prior personal history, of breast cancer;

(II) Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the insured's risk for breast cancer;

(III) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

(V) Other indications as determined by the insured's physician or advanced practice registered nurse;

(C) Breast biopsies;

(D) Prophylactic mastectomies for an insured who is believed to be at increased risk for breast cancer due to positive genetic testing for the

harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the insured's risk for breast cancer; and

(E) Breast reconstructive surgery for an insured who has undergone:

(i) A prophylactic mastectomy; or

(ii) A mastectomy as part of the insured's course of treatment for breast cancer.

(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, 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.

(d) Each mammography report provided to **[**a patient**]** an insured shall include information about breast density, based on the Breast Imaging Reporting and Data System established by the American College of Radiology. Where applicable, such report shall include the following notice: "If your mammogram demonstrates that you have dense breast tissue, which could hide small abnormalities, you might benefit from supplementary screening tests, which can include a breast ultrasound screening or a breast MRI examination, or both, depending on your individual risk factors. A report of your mammography results, which contains information about your breast density, has been sent to

your physician's or advanced practice registered nurse's office and you should contact your physician or advanced practice registered nurse if you have any questions or concerns about this report.".

Sec. 26. Section 38a-530 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) For purposes of this section:

(1) "Healthcare Common Procedure Coding System" or "HCPCS" means the billing codes used by Medicare and overseen by the federal Centers for Medicare and Medicaid Services that are based on the current procedural technology codes developed by the American Medical Association; and

(2) "Mammogram" means mammographic examination or breast tomosynthesis, including, but not limited to, a procedure with a HCPCS code of 77051, 77052, 77055, 77056, 77057, 77063, 77065, 77066, 77067, G0202, G0204, G0206 or G0279, or any subsequent corresponding code.

(b) (1) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for diagnostic and screening mammograms **[**to any woman covered under the policy**]** for insureds that are at least equal to the following minimum requirements:

(A) A baseline mammogram, which may be provided by breast tomosynthesis at the option of the **[**woman covered under the policy**]** insured, for **[**any woman**]** an insured who is: **[**thirty-five**]**

(i) Thirty-five to thirty-nine years of age, inclusive; **[**and**]** or

(ii) Younger than thirty-five years of age if the insured is believed to be at increased risk for breast cancer due to:

(I) A family history of breast cancer;

(II) Positive genetic testing for the harmful variant of breast cancer

gene one, breast cancer gene two or any other gene variant that materially increases the insured's risk for breast cancer;

(III) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

(V) Other indications as determined by the insured's physician or advanced practice registered nurse; and

(B) **[**a mammogram**]** Mammograms, which may be provided by breast tomosynthesis at the option of the **[**woman covered under the policy**]** insured, every year for **[**any woman**]** an insured who is: **[**forty**]**

(i) Forty years of age or older; **[**.**]** or

(ii) Younger than forty years of age if the insured is believed to be at increased risk for breast cancer due to:

(I) A family history, or prior personal history, of breast cancer;

(II) Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the insured's risk for breast cancer;

(III) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

(V) Other indications as determined by the insured's physician or advanced practice registered nurse.

(2) Such policy shall provide additional benefits for:

(A) Comprehensive [ultrasound screening] diagnostic and screening ultrasounds of an entire breast or breasts if:

(i) A mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or

(ii) [a woman] An insured is believed to be at increased risk for breast cancer due to:

(I) A family history, or prior personal history, of breast cancer; [,]

(II) [positive] Positive genetic testing [, or] for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the insured's risk for breast cancer;

(III) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

[(III) other] (V) Other indications as determined by [a woman's] the insured's physician or advanced practice registered nurse; [or (iii) such screening is recommended by a woman's treating physician for a woman who (I) is forty years of age or older, (II) has a family history or prior personal history of breast cancer, or (III) has a prior personal history of breast disease diagnosed through biopsy as benign; and]

(B) [Magnetic] Diagnostic and screening magnetic resonance imaging of an entire breast or breasts: [in]

(i) In accordance with guidelines established by the American Cancer Society [.] for an insured who is thirty-five years of age or older; or

(ii) If an insured is younger than thirty-five years of age and believed to be at increased risk for breast cancer due to:

(I) A family history, or prior personal history, of breast cancer;

(II) Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the insured's risk for breast cancer;

(III) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

(V) Other indications as determined by the insured's physician or advanced practice registered nurse;

(C) Breast biopsies;

(D) Prophylactic mastectomies for an insured who is believed to be at increased risk for breast cancer due to positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the insured's risk for breast cancer; and

(E) Breast reconstructive surgery for an insured who has undergone:

(i) A prophylactic mastectomy; or

(ii) A mastectomy as part of the insured's course of treatment for breast cancer.

(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, 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.

(d) Each mammography report provided to **[**a patient**]** an insured shall include information about breast density, based on the Breast Imaging Reporting and Data System established by the American College of Radiology. Where applicable, such report shall include the following notice: "If your mammogram demonstrates that you have dense breast tissue, which could hide small abnormalities, you might benefit from supplementary screening tests, which can include a breast ultrasound screening or a breast MRI examination, or both, depending on your individual risk factors. A report of your mammography results, which contains information about your breast density, has been sent to your physician's or advanced practice registered nurse's office and you should contact your physician or advanced practice registered nurse if you have any questions or concerns about this report.".

Sec. 27. Section 19a-193a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) Except as provided in subsection (c) of this section and subject to the provisions of sections 19a-177, 38a-498, as amended by this act, and 38a-525, as amended by this act, any person who receives emergency medical treatment services or transportation services from a licensed ambulance service, certified ambulance service or paramedic intercept service shall be liable to such ambulance service for the reasonable and necessary costs of providing such services, irrespective of whether such person agreed or consented to such liability.

(b) Except as provided in subsection (c) of this section, any person who receives medical services or transport services under nonemergency conditions from a mobile integrated health care program

shall be liable to such mobile health care integrated program for the reasonable and necessary costs of providing such services.

(c) The provisions of this section shall not apply to any person who receives: **[**emergency**]**

(1) Emergency medical treatment services or transportation services from a licensed ambulance service, certified ambulance service, paramedic intercept service or mobile integrated health care program for an injury arising out of and in the course of such person's employment as defined in section 31-275; **[**.**]** or

(2) Transportation services from a licensed ambulance service, certified ambulance service or paramedic intercept service if such service reasonably believes that such transportation services are nonemergency transportation services, unless such service, before providing such transportation services:

(A) Discloses to such person the potential cost to such person if such transportation services are nonemergency transportation services; and

(B) Receives written consent from such person to provide such transportation services.

Sec. 28. (NEW) (*Effective October 1, 2021*) (a) As used in this section, "mammogram" has the same meaning as provided in sections 38a-503 and 38a-530 of the general statutes, as amended by this act.

(b) Each health care provider who provides a mammogram to a patient shall provide to the patient:

(1) Advance notice disclosing whether a proposed test or examination to further investigate the results of the mammogram is:

(A) An elective test or examination; and

(B) Covered under the terms of the patient's health coverage; and

(2) An opportunity to determine whether the cost of a proposed test

or examination to further investigate the results of the mammogram is covered under the terms of the patient's health coverage.

(c) The Commissioner of Public Health may adopt regulations, in consultation with the Insurance Commissioner and in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2022*	New section
Sec. 2	*January 1, 2022*	New section
Sec. 3	*January 1, 2022*	New section
Sec. 4	*January 1, 2022*	New section
Sec. 5	*January 1, 2022*	New section
Sec. 6	*January 1, 2022*	New section
Sec. 7	*January 1, 2022*	New section
Sec. 8	*January 1, 2022*	New section
Sec. 9	*January 1, 2022*	New section
Sec. 10	*January 1, 2022*	New section
Sec. 11	*January 1, 2022*	New section
Sec. 12	*January 1, 2022*	New section
Sec. 13	*January 1, 2022*	New section
Sec. 14	*January 1, 2022*	New section
Sec. 15	*January 1, 2022*	New section
Sec. 16	*January 1, 2022*	New section
Sec. 17	*July 1, 2021*	New section
Sec. 18	*January 1, 2022*	38a-492c
Sec. 19	*January 1, 2022*	38a-518c
Sec. 20	*January 1, 2022*	38a-492k
Sec. 21	*January 1, 2022*	38a-518k
Sec. 22	*January 1, 2022*	38a-498
Sec. 23	*January 1, 2022*	38a-525
Sec. 24	*October 1, 2021*	New section
Sec. 25	*January 1, 2022*	38a-503
Sec. 26	*January 1, 2022*	38a-530
Sec. 27	*January 1, 2022*	19a-193a
Sec. 28	*October 1, 2021*	New section

Statement of Legislative Commissioners:

In Sections 25 and 26, Subsec. (b)(1) was redrafted for clarity and consistency and, in Subsec. (b)(2)(A)(ii)(V), the closing bracket after "benign;" was moved to after "and" for consistency.

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 22 $	FY 23 $
State Comptroller - Fringe Benefits	GF - Cost	Significant	Significant
State – ACA Mandate	GF - Cost	See Below	See Below
Insurance Dept.	GF - Cost	Up to $50,000	Up to $100,000
UConn Health Ctr.	GF - Revenue Gain	Minimal	Minimal

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 22 $	FY 23 $
Various Municipalities	STATE MANDATE[1] - Cost	See Below	See Below

Explanation

The bill requires that certain health insurance plans cover 11 newly mandated benefits[2], ambulance services are provided at in-network level of benefits, and the Insurance Department establish a program to increase breast cancer awareness. The bill results in the fiscal impact

[1] State mandate is defined in Sec. 2-32b(2) of the Connecticut General Statutes, "state mandate" means any state initiated constitutional, statutory or executive action that requires a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

[2] Benefits include: motorized wheelchairs; cochlear implants and surgery; coronary calcium tests; genetic cystic fibrosis screenings; certain physical therapies; equine therapy; gambling disorder treatment; audiologic, ophthalmologic, and optometric care; specialized formula; colorectal cancer diagnosis; mammograms.

described below.

There is a significant cost to the state employee and retiree health plan, municipalities that participate in the Partnership Plan, and fully-insured municipalities due to providing coverage for the newly included benefits, to the extent that the plans' policies are not currently in accordance with the provisions of the bill.

The cost to include any associated benefits not currently covered will be reflected in plan premiums for plan years starting on or after January 1, 2022. Premiums will increase based on the projected utilization of benefits, as determined by plan actuaries.

For illustration, the full estimated cost of a cochlear implant surgery, as a benefit mandated by the bill, is approximately $30,000-$50,000 per ear. It is also estimated that motorized wheelchairs cost approximately $2,000 - $7,000, including battery replacements.[3]

In addition, many municipal health plans are recognized as "grandfathered" health plans under the Affordable Care Act (ACA). It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA. Pursuant to federal law, municipalities with self-insured plans are exempt from state insurance mandates.

While self-insured plans are exempt from state insurance mandates, the state employee and retiree health plan has traditionally adopted them.

The bill will result in a cost to the state pursuant to the ACA to the extent the benefits are not currently covered under the Exchange's benchmark plan. Federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the Exchange, by reimbursing the carrier or the insured for the excess coverage. Absent

[3] The state employee and retiree health plan currently covers motorized wheelchairs as a benefit, however it is unknown if all fully-insured municipal plans or the Exchange benchmark plan cover them.

further federal guidance, state mandated benefits enacted after December 31, 2011 cannot be considered part of the essential health benefits required under federal law, unless they are already part of the benchmark plan.

The bill results in a potential minimal revenue gain to UConn Health Center, associated with the additional mandated benefits.

The bill has no fiscal impact to the Department of Social Services (DSS), as it currently covers audiologic, ophthalmologic, and optometric services under Medicaid.

Lastly, the bill results in a cost to the Insurance Department (DOI) of up to $100,000 annually (with a half year cost of up to $50,000 in FY 22), to implement a new breast cancer awareness program that includes outreach to young women of color. To implement the targeted outreach to individuals, it is anticipated that DOI would contract with a third-party vendor and incur such costs.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to an increase in future premiums and health care cost inflation.

OLR Bill Analysis

sHB 6626

AN ACT CONCERNING REQUIRED HEALTH INSURANCE AND MEDICAID COVERAGE, AMBULANCE SERVICES AND COST TRANSPARENCY.

SUMMARY

This bill requires certain individual and group commercial health insurance policies to cover the following benefits and services:

1. motorized wheelchairs, including used motorized wheelchairs, repairs, and replacement batteries (§§ 1 & 2);
2. cochlear implants and cochlear implant surgery, either unilateral or bilateral depending on the insured's hearing loss diagnosis (§§ 3 & 4);
3. medically necessary coronary calcium scan tests (§§ 5 & 6);
4. genetic cystic fibrosis screenings for women (§§ 7 & 8);
5. treatment of neurological conditions and diseases, including physical therapy to treat amyotrophic lateral sclerosis (§§ 9 & 10);
6. equine therapy for insureds who are veterans (§§ 11 & 12);
7. gambling disorder treatment (§§ 13 & 14);
8. audiologic, ophthalmologic, and optometric care (§§ 15 & 16);
9. specialized formula for insureds of any age (currently coverage is limited to children up to age 12) when it is medically necessary to treat a disease or condition and administered under a physician's direction (§§ 18 & 19);

10. colorectal cancer diagnosis, with no deductible for a procedure that began as a diagnostic colonoscopy or sigmoidoscopy (the law already requires coverage for colorectal cancer screenings) (§§ 20 & 21); and

11. diagnostic and screening mammograms, ultrasounds, and magnetic resonance imaging (MRIs); breast biopsies; certain prophylactic mastectomies; and breast reconstruction surgery, subject to certain conditions (§§ 25 & 26).

The bill also requires the Department of Social Services (DSS) commissioner to provide Medicaid reimbursement for audiologic, ophthalmologic, and optometric care; seek federal approval for this, if necessary; and adopt implementing regulations (§ 17).

The bill expands coverage under certain commercial health insurance policies for ambulance services and requires coverage at the in-network level of benefits (§§ 22 & 23). It also specifies that a person is not liable for nonemergency transportation services unless the provider discloses the potential cost to the person and receives the person's written consent for the services (§ 27).

Additionally, the bill requires the insurance commissioner to establish a program that advances breast health and breast cancer awareness and promotes early breast cancer detection (§ 24). He must do this by January 1, 2022, and within available appropriations. As part of the program, he must provide outreach to individuals, including young women of color.

Lastly, the bill requires a health care provider who performs a mammogram on a patient to provide the patient (1) advance notice of whether a proposed test or examination following the mammogram is elective and covered under the patient's health care plan and (2) an opportunity to determine if the proposed test or examination is covered under his or her health care plan (§ 28). It authorizes the public health commissioner, in consultation with the insurance commissioner, to adopt implementing regulations.

EFFECTIVE DATE: January 1, 2022, except for the provisions regarding Medicaid's reimbursement for audiologic, ophthalmologic, and optometric care, which are effective July 1, 2021; and the provisions requiring (1) the insurance commissioner to establish a breast health awareness program and (2) health care providers performing mammograms to provide advance notice to patients about proposed follow up testing, which are effective October 1, 2021.

§ 17 — MEDICAID REIMBURSEMENT REQUIREMENT

The bill requires the DSS commissioner to provide Medicaid reimbursement for audiologic, ophthalmologic, and optometric care and seek federal approval of a Medicaid state plan amendment or waiver for this, if necessary, in accordance with state law.

It also requires her to adopt implementing regulations. It authorizes her to adopt policies and procedures to implement these provisions while in the process of adopting regulations as long as the policies and procedures are posted on the DSS website and the state eRegulations system before they are adopted.

§§ 22-23 & 27 — AMBULANCE SERVICES

Commercial Insurance Coverage (§§ 22 & 23)

By law, certain individual and group health insurance policies must cover medically necessary ambulance services. The bill requires the policies to cover the ambulance services at the in-network level, including the in-network level of cost sharing.

Under existing law, the policies must cover, at a minimum, medically necessary ambulance services when an insured is transported to a hospital. The bill also requires the policies to cover medically necessary ambulance service from a hospital to the insured's residence.

By law, an ambulance service provider may bill a health carrier (e.g., insurer or HMO) for direct payment of emergency ambulance services if the provider has not been paid by any other source. In this case, the provider must indicate on the claim requesting payment that it is subject to assignment. The bill also authorizes the provider to indicate that it is

subject to assignment electronically if the claim is submitted electronically.

Liability for Nonemergency Ambulance Services (§ 27)

Under the bill, a person is not liable for nonemergency transportation services provided by a licensed or certified ambulance service or paramedic intercept service unless the provider, before providing the services, discloses their potential cost to the person and receives the person's written consent for the service.

§§ 25 & 26 — COMMERCIAL INSURANCE COVERAGE FOR BREAST CANCER SCREENINGS AND RELATED PROCEDURES

The bill expands coverage requirements for mammograms, ultrasounds, and MRIs under certain commercial health insurance policies and requires the policies to also cover specified related procedures.

As under existing law, the bill prohibits the policies from imposing cost sharing (coinsurance, copayment, deductible, or other out-of-pocket expenses) for the services. This cost-sharing prohibition applies to all affected policies, but only applies to high deductible health plans (1) to the extent federal law permits it and (2) as long as it does not disqualify a medical or health savings account from preferable tax treatment.

Mammograms

Under current law, the policies must cover a baseline mammogram for a woman aged 35 to 39 and an annual mammogram for a woman aged 40 or older. The bill instead requires the policies to cover diagnostic and screening mammograms at these age intervals for any insured, male or female.

It also requires the policies to cover a baseline mammogram for an insured who is younger than age 35 and an annual mammogram for an insured who is younger than age 40 if the insured is believed to be at in increased risk for breast cancer due to any of the following:

1. a family breast cancer history (or, if an annual mammogram, a personal breast cancer history);

1. positive genetic testing for the breast cancer gene one (BRCA1), breast cancer gene two (BRCA2), or other gene that materially increases the insured's breast cancer risk;

2. prior childhood cancer treatment that included radiation therapy to the chest;

3. prior or ongoing hormone treatment for gender reassignment; or

4. other indications the insured's physician or advanced practice registered nurse (APRN) determines.

Breast Ultrasounds

Current law requires the policies to cover a comprehensive breast ultrasound screening if a mammogram demonstrates the woman has dense breast tissue or is at increased risk for breast cancer based on family or personal breast cancer history or other indications her physician or APRN determines.

The bill instead requires the policies to cover both diagnostic and screening breast ultrasounds for any insured whose mammogram demonstrates the insured has dense breast tissue or is at increased breast cancer due to any of the following:

1. a family or personal breast cancer history;

2. positive genetic testing for BRCA1, BRCA2, or other gene that materially increases the insured's breast cancer risk;

3. prior childhood cancer treatment that included radiation therapy to the chest;

4. prior or ongoing hormone treatment for gender reassignment; or

5. other indications the insured's physician or APRN determines.

Breast MRIs

Current law requires the policies to cover a woman's breast MRI in accordance with American Cancer Society guidelines.

The bill instead requires the policies to cover both diagnostic and screening breast MRIs in accordance with the American Cancer Society guidelines for an insured who is (1) age 35 or older or (2) younger than age 35 who is at increased breast cancer risk due to the same five reasons listed above for ultrasound coverage.

Related Procedures

The bill requires the policies to also cover the following:

1. breast biopsies;

2. prophylactic mastectomies for an insured at increased breast cancer risk due to positive genetic testing for BRCA1, BRCA2, or other gene that materially increases the insured's breast cancer risk; and

3. breast reconstructive surgery for an insured who has had a prophylactic mastectomy or mastectomy as part of breast cancer treatment.

APPLICABILITY OF COMMERCIAL INSURANCE REQUIREMENTS

The bill's commercial insurance requirements apply to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2022, 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. The breast health benefit requirements (§§ 25 & 26) also apply to individual and group health insurance policies that provide limited benefit coverage.

Under current law, the ambulance services benefit requirements (§§ 22 & 23) also apply to (1) individual health insurance policies that cover limited benefits or accidents only and (2) group health insurance

policies that cover accidents only. The bill eliminates this applicability.

Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 17 Nay 1 (03/22/2021)