



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:

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

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

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

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

26 Sec. 4. (NEW) (*Effective January 1, 2022*) Each group health insurance
27 policy providing coverage of the type specified in subdivisions (1), (2),
28 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
29 issued for delivery, renewed, amended or continued in this state on or
30 after January 1, 2022, shall provide coverage for: (1) A unilateral
31 cochlear implant, and unilateral cochlear implant surgery, for an
32 insured who has been diagnosed with unilateral hearing loss; and (2)
33 bilateral cochlear implants, and bilateral cochlear implant surgery, for
34 an insured who has been diagnosed with bilateral hearing loss.

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

41 Sec. 6. (NEW) (*Effective January 1, 2022*) Each group health insurance
42 policy providing coverage of the type specified in subdivisions (1), (2),
43 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
44 issued for delivery, renewed, amended or continued in this state on or
45 after January 1, 2022, shall provide coverage for medically necessary
46 coronary calcium scan tests.

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

53 Sec. 8. (NEW) (*Effective January 1, 2022*) Each group health insurance
54 policy providing coverage of the type specified in subdivisions (1), (2),
55 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
56 issued for delivery, renewed, amended or continued in this state on or
57 after January 1, 2022, shall provide coverage for genetic cystic fibrosis
58 screenings for women.

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

67 Sec. 10. (NEW) (*Effective January 1, 2022*) Each group health insurance
68 policy providing coverage of the type specified in subdivisions (1), (2),
69 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
70 issued for delivery, renewed, amended or continued in this state on or
71 after January 1, 2022, shall provide coverage for the treatment of
72 neurological conditions and diseases, including, but not limited to,
73 physical therapy for the treatment of amyotrophic lateral sclerosis.

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

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

82 Sec. 12. (NEW) (*Effective January 1, 2022*) Each group health insurance
83 policy providing coverage of the type specified in subdivisions (1), (2),
84 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
85 issued for delivery, renewed, amended or continued in this state on or
86 after January 1, 2022, shall provide coverage for equine therapy for an
87 insured who is a veteran. For the purposes of this section, "veteran" has
88 the same meaning as provided in section 27-103 of the general statutes.

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

98 Sec. 14. (NEW) (*Effective January 1, 2022*) Each group health insurance
99 policy providing coverage of the type specified in subdivisions (1), (2),
100 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
101 issued for delivery, renewed, amended or continued in this state on or
102 after January 1, 2022, shall provide coverage for gambling disorder
103 treatment. For the purposes of this section, "gambling disorder" has the
104 same meaning as provided in the most recent edition of the American
105 Psychiatric Association's "Diagnostic and Statistical Manual of Mental
106 Disorders".

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

113 Sec. 16. (NEW) (*Effective January 1, 2022*) Each group health insurance
114 policy providing coverage of the type specified in subdivisions (1), (2),
115 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
116 issued for delivery, renewed, amended or continued in this state on or
117 after January 1, 2022, shall provide coverage for audiologic,
118 ophthalmologic and optometric care.

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

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

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

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

137 (a) For purposes of this section:

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

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

144 of a physician.

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

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

154 (b) Each individual health insurance policy providing coverage of the
155 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
156 delivered, issued for delivery, renewed, amended or continued in this
157 state shall provide coverage for amino acid modified preparations and
158 low protein modified food products for the treatment of inherited
159 metabolic diseases if the amino acid modified preparations or low
160 protein modified food products are prescribed for the therapeutic
161 treatment of inherited metabolic diseases and are administered under
162 the direction of a physician.

163 (c) Each individual health insurance policy providing coverage of the
164 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
165 delivered, issued for delivery, renewed, amended or continued in this
166 state shall provide coverage for specialized formulas when such
167 specialized formulas are medically necessary for the treatment of a
168 disease or condition and are administered under the direction of a
169 physician.

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

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

175 (a) For purposes of this section:

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

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

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

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

192 (b) Each group health insurance policy providing coverage of the
193 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
194 delivered, issued for delivery, renewed, amended or continued in this
195 state shall provide coverage for amino acid modified preparations and
196 low protein modified food products for the treatment of inherited
197 metabolic diseases if the amino acid modified preparations or low
198 protein modified food products are prescribed for the therapeutic
199 treatment of inherited metabolic diseases and are administered under
200 the direction of a physician.

201 (c) Each group health insurance policy providing coverage of the type
202 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
203 delivered, issued for delivery, renewed, amended or continued in this
204 state shall provide coverage for specialized formulas when such
205 specialized formulas are medically necessary for the treatment of a

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

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

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

213 (a) Each individual health insurance policy providing coverage of the
214 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
215 delivered, issued for delivery, amended, renewed or continued in this
216 state shall provide coverage for colorectal cancer screening and
217 diagnosis, including, but not limited to, (1) an annual fecal occult blood
218 test, and (2) colonoscopy, flexible sigmoidoscopy or radiologic imaging,
219 in accordance with the recommendations established by the American
220 Cancer Society, based on the ages, family histories and frequencies
221 provided in the recommendations. Except as specified in subsection (b)
222 of this section, benefits under this section shall be subject to the same
223 terms and conditions applicable to all other benefits under such policies.

224 (b) No such policy shall impose:

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

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

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

235 (a) Each group health insurance policy providing coverage of the type

236 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
237 delivered, issued for delivery, amended, renewed or continued in this
238 state shall provide coverage for colorectal cancer screening and
239 diagnosis, including, but not limited to, (1) an annual fecal occult blood
240 test, and (2) colonoscopy, flexible sigmoidoscopy or radiologic imaging,
241 in accordance with the recommendations established by the American
242 Cancer Society, based on the ages, family histories and frequencies
243 provided in the recommendations. Except as specified in subsection (b)
244 of this section, benefits under this section shall be subject to the same
245 terms and conditions applicable to all other benefits under such policies.

246 (b) No such policy shall impose:

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

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

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

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

267 (A) To a hospital; [Such] or

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

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

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

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

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

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

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

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

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

298 (a) (1) Each group health insurance policy providing coverage of the
299 type specified in subdivisions (1), (2), (4), ~~[(6),]~~ (11) and (12) of section
300 38a-469 delivered, issued for delivery, renewed, amended or continued
301 in this state shall provide coverage for medically necessary ambulance
302 services for persons covered by the policy at an in-network level,
303 including an in-network level of cost-sharing. The hospital policy shall
304 be primary if a person is covered under more than one policy. The policy
305 shall, as a minimum requirement, cover such services whenever any
306 person covered by the contract is transported, when medically
307 necessary, by ambulance; [to]

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

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

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

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

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

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

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

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

337 Sec. 24. (NEW) (*Effective October 1, 2021*) Not later than January 1,
338 2022, the Insurance Commissioner shall, within available
339 appropriations, establish a program to advance breast health and breast
340 cancer awareness, and promote greater understanding of the
341 importance of early breast cancer detection, in this state. As part of the
342 program, the commissioner shall, at a minimum, provide outreach to
343 individuals, including, but not limited to, young women of color, in this
344 state regarding the importance of breast health and early breast cancer
345 detection.

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

348 (a) For purposes of this section:

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

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

358 (b) (1) Each individual health insurance policy providing coverage of
359 the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section
360 38a-469 delivered, issued for delivery, renewed, amended or continued
361 in this state shall provide benefits for diagnostic and screening
362 mammograms [to any woman covered under the policy] for insureds
363 that are at least equal to the following minimum requirements:

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

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

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

370 (I) A family history of breast cancer;

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

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

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

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

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

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

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

386 increased risk for breast cancer due to:

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

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

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

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

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

398 (2) Such policy shall provide additional benefits for:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

438 (C) Breast biopsies;

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

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

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

445 (i) A prophylactic mastectomy; or

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

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

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

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

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

478 (a) For purposes of this section:

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

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

488 (b) (1) Each group health insurance policy providing coverage of the
489 type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section
490 38a-469 delivered, issued for delivery, renewed, amended or continued
491 in this state shall provide benefits for diagnostic and screening
492 mammograms [to any woman covered under the policy] for insureds
493 that are at least equal to the following minimum requirements:

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

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

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

500 (I) A family history of breast cancer;

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

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

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

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

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

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

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

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

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

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

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

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

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

528 (2) Such policy shall provide additional benefits for:

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

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

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

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

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

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

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

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

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

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

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

- 557 (I) A family history, or prior personal history, of breast cancer;
- 558 (II) Positive genetic testing for the harmful variant of breast cancer
559 gene one, breast cancer gene two or any other gene that materially
560 increases the insured's risk for breast cancer;
- 561 (III) Prior treatment for a childhood cancer if the course of treatment
562 for the childhood cancer included radiation therapy directed at the
563 chest;
- 564 (IV) Prior or ongoing hormone treatment as part of a gender
565 reassignment; or
- 566 (V) Other indications as determined by the insured's physician or
567 advanced practice registered nurse;
- 568 (C) Breast biopsies;
- 569 (D) Prophylactic mastectomies for an insured who is believed to be at
570 increased risk for breast cancer due to positive genetic testing for the
571 harmful variant of breast cancer gene one, breast cancer gene two or any
572 other gene that materially increases the insured's risk for breast cancer;
573 and
- 574 (E) Breast reconstructive surgery for an insured who has undergone:
- 575 (i) A prophylactic mastectomy; or
- 576 (ii) A mastectomy as part of the insured's course of treatment for
577 breast cancer.

578 (c) Benefits under this section shall be subject to any policy provisions
579 that apply to other services covered by such policy, except that no such
580 policy shall impose a coinsurance, copayment, deductible or other out-
581 of-pocket expense for such benefits. The provisions of this subsection
582 shall apply to a high deductible health plan, as that term is used in
583 subsection (f) of section 38a-520, to the maximum extent permitted by
584 federal law, except if such plan is used to establish a medical savings
585 account or an Archer MSA pursuant to Section 220 of the Internal

586 Revenue Code of 1986 or any subsequent corresponding internal
587 revenue code of the United States, as amended from time to time, or a
588 health savings account pursuant to Section 223 of said Internal Revenue
589 Code, as amended from time to time, the provisions of this subsection
590 shall apply to such plan to the maximum extent that (1) is permitted by
591 federal law, and (2) does not disqualify such account for the deduction
592 allowed under said Section 220 or 223, as applicable.

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

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

608 (a) Except as provided in subsection (c) of this section and subject to
609 the provisions of sections 19a-177, 38a-498, as amended by this act, and
610 38a-525, as amended by this act, any person who receives emergency
611 medical treatment services or transportation services from a licensed
612 ambulance service, certified ambulance service or paramedic intercept
613 service shall be liable to such ambulance service for the reasonable and
614 necessary costs of providing such services, irrespective of whether such
615 person agreed or consented to such liability.

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

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

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

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

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

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

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

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

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

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

644 (A) An elective test or examination; and

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

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

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

649 (c) The Commissioner of Public Health may adopt regulations, in
650 consultation with the Insurance Commissioner and in accordance with
651 the provisions of chapter 54 of the general statutes, to implement the
652 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 benefits², 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 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)