



General Assembly

January Session, 2021

**Raised Bill No. 6626**

LCO No. 3769



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:  
(INS)

***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), (10), (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  
359 of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of  
360 section 38a-469 delivered, issued for delivery, renewed, amended or  
361 continued in this state shall provide benefits for:

362 (1) Diagnostic and screening mammograms [to any woman covered  
363 under the policy] for insureds that are at least equal to the following  
364 minimum requirements:

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

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

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

371 (I) A family history of breast cancer;

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

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

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

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

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

385 (i) Forty years of age or older; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

436 reassignment; or

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

439 (C) Breast biopsies;

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

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

446 (i) A prophylactic mastectomy; or

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

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

464 (d) Each mammography report provided to [a patient] an insured  
465 shall include information about breast density, based on the Breast



466 Imaging Reporting and Data System established by the American  
467 College of Radiology. Where applicable, such report shall include the  
468 following notice: "If your mammogram demonstrates that you have  
469 dense breast tissue, which could hide small abnormalities, you might  
470 benefit from supplementary screening tests, which can include a breast  
471 ultrasound screening or a breast MRI examination, or both, depending  
472 on your individual risk factors. A report of your mammography results,  
473 which contains information about your breast density, has been sent to  
474 your physician's or advanced practice registered nurse's office and you  
475 should contact your physician or advanced practice registered nurse if  
476 you have any questions or concerns about this report."

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

479 (a) For purposes of this section:

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

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

489 (b) [(1)] Each group health insurance policy providing coverage of the  
490 type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section  
491 38a-469 delivered, issued for delivery, renewed, amended or continued  
492 in this state shall provide benefits for:

493 (1) Diagnostic and screening mammograms [to any woman covered  
494 under the policy] for insureds that are at least equal to the following  
495 minimum requirements:

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

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

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

502 (I) A family history of breast cancer;

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

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

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

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

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

516 (i) Forty years of age or older; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

551 prior personal history of breast cancer, or (III) has a prior personal  
552 history of breast disease diagnosed through biopsy as benign;] and

553 (B) [Magnetic] Diagnostic and screening magnetic resonance imaging  
554 of an entire breast or breasts;

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

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

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

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

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

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

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

570 (C) Breast biopsies;

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

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

577 (i) A prophylactic mastectomy; or

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

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

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

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

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

618 (b) Except as provided in subsection (c) of this section, any person  
619 who receives medical services or transport services under  
620 nonemergency conditions from a mobile integrated health care program  
621 shall be liable to such mobile health care integrated program for the  
622 reasonable and necessary costs of providing such services.

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

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

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

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

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

639 Sec. 28. (NEW) (*Effective October 1, 2021*) (a) As used in this section,

640 "mammogram" has the same meaning as provided in sections 38a-503  
 641 and 38a-530 of the general statutes, as amended by this act.

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

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

646 (A) An elective test or examination; and

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

648 (2) An opportunity to determine whether the cost of a proposed test  
 649 or examination to further investigate the results of the mammogram is  
 650 covered under the terms of the patient's health coverage.

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2022</i>	New section
Sec. 2	<i>January 1, 2022</i>	New section
Sec. 3	<i>January 1, 2022</i>	New section
Sec. 4	<i>January 1, 2022</i>	New section
Sec. 5	<i>January 1, 2022</i>	New section
Sec. 6	<i>January 1, 2022</i>	New section
Sec. 7	<i>January 1, 2022</i>	New section
Sec. 8	<i>January 1, 2022</i>	New section
Sec. 9	<i>January 1, 2022</i>	New section
Sec. 10	<i>January 1, 2022</i>	New section
Sec. 11	<i>January 1, 2022</i>	New section
Sec. 12	<i>January 1, 2022</i>	New section
Sec. 13	<i>January 1, 2022</i>	New section
Sec. 14	<i>January 1, 2022</i>	New section
Sec. 15	<i>January 1, 2022</i>	New section

Sec. 16	<i>January 1, 2022</i>	New section
Sec. 17	<i>July 1, 2021</i>	New section
Sec. 18	<i>January 1, 2022</i>	38a-492c
Sec. 19	<i>January 1, 2022</i>	38a-518c
Sec. 20	<i>January 1, 2022</i>	38a-492k
Sec. 21	<i>January 1, 2022</i>	38a-518k
Sec. 22	<i>January 1, 2022</i>	38a-498
Sec. 23	<i>January 1, 2022</i>	38a-525
Sec. 24	<i>October 1, 2021</i>	New section
Sec. 25	<i>January 1, 2022</i>	38a-503
Sec. 26	<i>January 1, 2022</i>	38a-530
Sec. 27	<i>January 1, 2022</i>	19a-193a
Sec. 28	<i>October 1, 2021</i>	New section

**Statement of Purpose:**

To: (1) Require certain individual and group health insurance policies to provide coverage for (A) motorized wheelchairs, including, but not limited to, (i) used motorized wheelchairs, (ii) repairs to motorized wheelchairs, and (iii) replacement batteries for motorized wheelchairs, (B) cochlear implants and cochlear implant surgery for insureds diagnosed with hearing loss, (C) medically necessary coronary calcium scan tests, (D) genetic cystic fibrosis screenings for women, (E) the treatment of neurological conditions and diseases, including, but not limited to, physical therapy for the treatment of amyotrophic lateral sclerosis, (F) equine therapy for veterans, (G) gambling disorder treatment, (H) audiologic, ophthalmologic and optometric care, and (I) specialized formulas for individuals twelve years of age or older; (2) require Medicaid coverage for audiologic, ophthalmologic and optometric care; (3) (A) modify required health insurance coverage for ambulance services to (i) include medically necessary transportation to a covered person's place of residence, and (ii) require that such benefits be provided at an in-network level, (B) provide for electronic notification of assignments of bills for ambulance services, and (C) require an ambulance provider to notify, and obtain consent from, a person before providing transportation services to the person if the provider reasonably believes that such services are not emergency services; (4) require the Insurance Commissioner to, 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; (5) expand required health insurance coverage under certain individual and group health insurance policies to include coverage for (A) colorectal cancer



diagnoses and related benefits, (B) breast health and breast cancer benefits regardless of sex, (C) diagnostic and screening (i) mammograms, including, but not limited to, (I) baseline mammograms for certain insureds younger than thirty-five years of age, and (II) annual mammograms for certain insureds younger than forty years of age, (ii) comprehensive breast ultrasounds, and (iii) magnetic resonance imaging of an entire breast or breasts, (D) breast biopsies, (E) prophylactic mastectomies for certain insureds, and (F) breast reconstructive surgery for certain insureds; and (6) (A) require a health care provider who provides a mammogram to a patient to provide to the patient (i) advance notice disclosing information regarding certain tests or examinations proposed to further investigate the results of the mammogram, and (ii) an opportunity to determine whether the cost of such proposed tests or examinations are covered under the terms of the patient's health coverage, and (B) authorize the Commissioner of Public Health, in consultation with the Insurance Commissioner, to adopt regulations.

*[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]*