January Session, 2021

Proposed Substitute Bill No. 6626

LCO No. **5747**

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 <u>and</u>
217 <u>diagnosis</u>, 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 <u>or diagnostic</u> 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) <u>(1)</u> 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 <u>at an in-network level,</u>
303 <u>including an in-network level of cost-sharing</u>. 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<u>,</u> when medically
307 necessary<u>,</u> by ambulance<u>:</u> **[**to**]**

308 <u>(A) To</u> a hospital<u>;</u> **[**. Such**]** <u>or</u>

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

310 <u>(2) Except as otherwise provided in this section, the</u> benefits <u>required</u>
311 <u>under this section</u> shall be subject to any policy provision which applies
312 to other services covered by **[**such**]** <u>the</u> policies <u>that are subject to this</u>
313 <u>section</u>. 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	*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