General Assembly

**Raised Bill No. 5175**

*February Session, 2020*

LCO No. **1547**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

***AN ACT CONCERNING DIABETES AND HIGH DEDUCTIBLE HEALTH PLANS.***

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

Section 1. Section 38a-492d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2021*):

(a) For the purposes of this section:

(1) "Diabetes equipment and supplies" means equipment and supplies that are used to treat diabetes, including, but not limited to, blood glucose test strips, glucometers, lancets, lancing devices and insulin syringes;

(2) "High deductible health plan" has the same meaning as that term is used in subsection (f) of section 38a-493, as amended by this act;

(3) "Insulin drug" means a drug that contains insulin and is approved by the federal Food and Drug Administration to treat diabetes, including, but not limited to, insulin pens;

(4) "Noninsulin drug" means a drug that does not contain insulin and

is approved by the federal Food and Drug Administration to treat diabetes, including, but not limited to, glucagen, glucose tablets and glucose gels; and

(5) "Prescribing practitioner" has the same meaning as provided in section 20-571.

**[**(a) Each**]** (b) Notwithstanding the provisions of section 38a-492a, each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery**,** **[**or**]** renewed, amended or continued in this state shall provide coverage for **[**laboratory**]** the treatment of all types of diabetes. Such coverage shall include, but need not be limited to, coverage for medically necessary:

(1) Laboratory and diagnostic **[**tests**]** testing and screening, including, but not limited to, hemoglobin A1c testing and retinopathy screening, for all types of diabetes;

(2) Insulin drugs (A) prescribed by a prescribing practitioner, or (B) dispensed pursuant to subsection (b) of section 3 of this act not more than three times during a policy year;

(3) Noninsulin drugs prescribed by a prescribing practitioner; and

(4) Diabetes equipment and supplies in accordance with the insured's diabetes treatment plan.

**[**(b) Notwithstanding the provisions of section 38a-492a, each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed in this state shall provide medically necessary coverage for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes. Such coverage shall include medically necessary equipment, in accordance with the insured person's treatment plan, drugs and supplies prescribed by a prescribing practitioner, as defined

in section 20-571.**]**

(c) (1) Notwithstanding the provisions of section 38a-492a and except as provided in subdivision (2) of this subsection, no policy described in subsection (b) of this section shall impose coinsurance, copayments, deductibles and other out-of-pocket expenses on an insured that exceed:

(A) Fifty dollars for each thirty-day supply of a medically necessary covered insulin drug prescribed to the insured by a prescribing practitioner;

(B) Fifty dollars for each thirty-day supply of a medically necessary covered noninsulin drug prescribed to the insured by a prescribing practitioner; or

(C) One hundred dollars for a thirty-day supply of all medically necessary covered diabetes equipment and supplies for such insured that are in accordance with such insured's diabetes treatment plan.

(2) The combined monthly coinsurance, copayments, deductibles and other out-of-pocket expenses for all medically necessary covered insulin drugs prescribed to an insured by a prescribing practitioner and all medically necessary covered diabetes equipment and supplies for the insured shall not exceed one hundred dollars, provided such diabetes equipment and supplies are in accordance with such insured's diabetes treatment plan.

(d) The provisions of subsection (c) of this section shall apply to a high deductible health plan to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account pursuant to Section 223 of said Internal Revenue Code, as amended from time to time, the provisions of said subsection (c) shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed

under said Section 220 or 223, as applicable.

Sec. 2. Section 38a-518d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2021*):

(a) For the purposes of this section:

(1) "Diabetes equipment and supplies" means equipment and supplies that are used to treat diabetes, including, but not limited to, blood glucose test strips, glucometers, lancets, lancing devices and insulin syringes;

(2) "High deductible health plan" has the same meaning as that term is used in subsection (f) of section 38a-520, as amended by this act;

(3) "Insulin drug" means a drug that contains insulin and is approved by the federal Food and Drug Administration to treat diabetes, including, but not limited to, insulin pens;

(4) "Noninsulin drug" means a drug that does not contain insulin and is approved by the federal Food and Drug Administration to treat diabetes, including, but not limited to, glucagen, glucose tablets and glucose gels; and

(5) "Prescribing practitioner" has the same meaning as provided in section 20-571.

**[**(a) Each**]** (b) Notwithstanding the provisions of section 38a-518a, each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, **[**or**]** renewed, amended or continued in this state shall provide coverage for **[**laboratory**]** the treatment of all types of diabetes. Such coverage shall include, but need not be limited to, coverage for medically necessary:

(1) Laboratory and diagnostic **[**tests**]** testing and screening, including, but not limited to, hemoglobin A1c testing and retinopathy screening, for all types of diabetes;

(2) Insulin drugs (A) prescribed by a prescribing practitioner, or (B) dispensed pursuant to subsection (b) of section 3 of this act not more than three times during a policy year;

(3) Noninsulin drugs prescribed by a prescribing practitioner; and

(4) Diabetes equipment and supplies, provided such diabetes equipment and supplies are in accordance with the insured's diabetes treatment plan.

**[**(b) Notwithstanding the provisions of section 38a-518a, each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed in this state shall provide medically necessary coverage for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes. Such coverage shall include medically necessary equipment, in accordance with the insured person's treatment plan, drugs and supplies prescribed by a prescribing practitioner, as defined in section 20-571.**]**

(c) (1) Notwithstanding the provisions of section 38a-518a and except as provided in subdivision (2) of this subsection, no policy described in subsection (b) of this section shall impose coinsurance, copayments, deductibles and other out-of-pocket expenses on an insured that exceed:

(A) Fifty dollars for each thirty-day supply of a medically necessary covered insulin drug prescribed to the insured by a prescribing practitioner;

(B) Fifty dollars for each thirty-day supply of a medically necessary covered noninsulin drug prescribed to the insured by a prescribing practitioner; or

(C) One hundred dollars for a thirty-day supply of all medically necessary covered diabetes equipment and supplies for such insured that are in accordance with such insured's diabetes treatment plan.

(2) The combined monthly coinsurance, copayments, deductibles and other out-of-pocket expenses for all medically necessary covered insulin drugs prescribed to an insured by a prescribing practitioner and all medically necessary covered diabetes equipment and supplies for the insured shall not exceed one hundred dollars, provided such diabetes equipment and supplies are in accordance with such insured's diabetes treatment plan.

(d) The provisions of subsection (c) of this section shall apply to a high deductible health plan to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account pursuant to Section 223 of said Internal Revenue Code, as amended from time to time, the provisions of said subsection (c) shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable.

Sec. 3. (NEW) (*Effective from passage*) (a) For the purposes of this section:

(1) "Diabetes equipment and supplies" has the same meaning as provided in sections 38a-492d and 38a-518d of the general statutes, as amended by this act;

(2) "Insulin drug" has the same meaning as provided in sections 38a-492d and 38a-518d of the general statutes, as amended by this act; and

(3) "Pharmacist" means a pharmacist licensed under chapter 400j of the general statutes.

(b) Notwithstanding any provision of the general statutes, a pharmacist shall immediately dispense a prescription insulin drug or prescription diabetes equipment and supplies to an individual in this state who does not have a valid prescription for such insulin drug or

diabetes equipment and supplies if the pharmacist determines, in such pharmacist's professional judgment, that such individual would suffer immediate physical harm if such pharmacist did not immediately dispense such insulin drug or diabetes equipment and supplies to such individual. Such pharmacist shall dispense to such individual the minimum amount of such insulin drug or diabetes equipment and supplies necessary to ensure that such individual does not suffer immediate physical harm because such individual does not possess such insulin drug or diabetes equipment and supplies.

(c) Not later than January 1, 2021, the Commissioner of Consumer Protection shall send a notice, in a form and manner determined by the commissioner, to each pharmacist disclosing the requirements of subsection (b) of this section.

(d) The Commissioner of Consumer Protection may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 4. (*Effective from passage*) (a) The Commissioner of Social Services shall conduct a study regarding the feasibility of expanding the program established under section 17b-363a of the general statutes to include a fund for the purpose of assisting low-income diabetic individuals in this state to pay for insulin and equipment and supplies used to treat diabetes.

(b) Not later than January 1, 2021, the commissioner shall submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and insurance disclosing the results of the study conducted by the commissioner pursuant to subsection (a) of this section.

Sec. 5. Subsection (f) of section 38a-493 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(f) Home health care benefits may be subject to an annual deductible of not more than fifty dollars for each person covered under a policy and may be subject to a coinsurance provision that provides for coverage of not less than seventy-five per cent of the reasonable charges for such services. Such policy may also contain reasonable limitations and exclusions applicable to home health care coverage. A high deductible health plan, as defined in Section 220(c)(2) or Section 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, used to establish a medical savings account or an Archer MSA pursuant to Section 220 of said Internal Revenue Code or a health savings account pursuant to Section 223 of said Internal Revenue Code shall not be subject to the deductible limits set forth in this subsection.

Sec. 6. Subsection (b) of section 38a-490a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such services, except that a high deductible health plan, as that term is used in subsection (f) of section 38a-493, as amended by this act, shall not be subject to the deductible limits set forth in this section.

Sec. 7. Subdivision (2) of subsection (b) of section 38a-492k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

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

Sec. 8. Subsection (b) of section 38a-492o of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October*

*1, 2020*):

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such testing in excess of twenty per cent of the cost for such testing per year. The provisions of this subsection shall not apply to a high deductible health plan as that term is used in subsection (f) of section 38a-493, as amended by this act.

Sec. 9. Subsection (b) of section 38a-492r of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(b) No policy described in subsection (a) of this section shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under said subsection. The provisions of this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section 38a-493, as amended by this act, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account **[**, as that term is used in**]** pursuant to Section 223 of **[**the**]** said Internal Revenue Code, **[**of 1986 or any subsequent corresponding internal revenue code of the United States,**]** as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable. Nothing in this section shall preclude a policy that provides the coverage required under subsection (a) of this section and uses a provider network from imposing cost-sharing requirements for any benefit or service required under said subsection (a) that is delivered by an out-of-network provider.

Sec. 10. Subsection (b) of section 38a-492s of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October*

*1, 2020*):

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under subsection (a) of this section. The provisions of this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section 38a-493, as amended by this act, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account **[**, as that term is used in**]** pursuant to Section 223 of **[**the**]** said Internal Revenue Code, **[**of 1986 or any subsequent corresponding internal revenue code of the United States,**]** as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable. Nothing in this section shall preclude a policy that provides the coverage required under subsection (a) of this section and uses a provider network from imposing cost-sharing requirements for any benefit or service required under said subsection (a) that is delivered by an out-of-network provider.

Sec. 11. Subdivision (3) of subsection (b) of section 38a-492t of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(3) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for a prosthetic device that is more restrictive than that imposed on substantially all other benefits provided under such policy, except that a high deductible health plan, as that term is used in subsection (f) of section 38a-493, as amended by this act, shall not be subject to the deductible limits set forth in this subdivision or under Medicare pursuant to subdivision (1) of this subsection.

Sec. 12. Subsection (c) of section 38a-503 of the 2020 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

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

Sec. 13. Subsection (b) of section 38a-503e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(b) No policy described in subsection (a) of this section shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under said subsection (a), except that any such policy that uses a provider network may require cost-sharing when such benefits and services are rendered by an out-of-network provider. The cost-sharing limits imposed under this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section 38a-493, as amended by this act, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or any subsequent corresponding

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

Sec. 14. Subsection (b) of section 38a-503f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(b) No policy described in subsection (a) of this section shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under said subsection. The provisions of this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section 38a-493, as amended by this act, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account **[**, as that term is used in**]** pursuant to Section 223 of **[**the**]** said Internal Revenue Code, **[**of 1986 or any subsequent corresponding internal revenue code of the United States,**]** as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable. Nothing in this section shall preclude a policy that provides the coverage required under subsection (a) of this section and uses a provider network from imposing cost-sharing requirements for any benefit or service required under said subsection (a) that is delivered by an out-of-network provider.

Sec. 15. Subsection (c) of section 38a-511 of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(c) The provisions of subsections (a) and (b) of this section shall not apply to a high deductible health plan as that term is used in subsection (f) of section 38a-493, as amended by this act.

Sec. 16. Subsection (f) of section 38a-520 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(f) Home health care benefits may be subject to an annual deductible of not more than fifty dollars for each person covered under a policy and may be subject to a coinsurance provision that provides for coverage of not less than seventy-five per cent of the reasonable charges for such services. Such policy may also contain reasonable limitations and exclusions applicable to home health care coverage. A high deductible health plan, as defined in Section 220(c)(2) or Section 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, used to establish a medical savings account or an Archer MSA pursuant to Section 220 of said Internal Revenue Code or a health savings account pursuant to Section 223 of said Internal Revenue Code shall not be subject to the deductible limits set forth in this subsection.

Sec. 17. Subsection (b) of section 38a-516a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such services, except that a high deductible health plan, as that term is used in subsection (f) of section 38a-520, as amended by this act, shall not be subject to the deductible limits set forth in this section.

Sec. 18. Subdivision (2) of subsection (b) of section 38a-518k of the

general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

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

Sec. 19. Subsection (b) of section 38a-518o of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such testing in excess of twenty per cent of the cost for such testing per year. The provisions of this subsection shall not apply to a high deductible health plan as that term is used in subsection (f) of section 38a-520, as amended by this act.

Sec. 20. Subsection (b) of section 38a-518r of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(b) No policy described in subsection (a) of this section shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under said subsection. The provisions of this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section **[**38a-493**]** 38a-520, as amended by this act, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account **[**, as that term is used in**]** pursuant to Section 223 of **[**the**]** said Internal Revenue Code, **[**of 1986 or any subsequent corresponding internal revenue code of the United States,**]** as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum

extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable. Nothing in this section shall preclude a policy that provides the coverage required under subsection (a) of this section and uses a provider network from imposing cost-sharing requirements for any benefit or service required under said subsection (a) that is delivered by an out-of-network provider.

Sec. 21. Subsection (b) of section 38a-518s of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under subsection (a) of this section. The provisions of this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section **[**38a-493**]** 38a-520, as amended by this act, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account **[**, as that term is used in**]** pursuant to Section 223 of **[**the**]** said Internal Revenue Code, **[**of 1986 or any subsequent corresponding internal revenue code of the United States,**]** as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable. Nothing in this section shall preclude a policy that provides the coverage required under subsection (a) of this section and uses a provider network from imposing cost-sharing requirements for any benefit or service required under said subsection (a) that is delivered by an out-of-network provider.

Sec. 22. Subdivision (3) of subsection (b) of section 38a-518t of the general statutes is repealed and the following is substituted in lieu

thereof (*Effective October 1, 2020*):

(3) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for a prosthetic device that is more restrictive than that imposed on substantially all other benefits provided under such policy, except that a high deductible health plan, as that term is used in subsection (f) of section 38a-520, as amended by this act, shall not be subject to the deductible limits set forth in this subdivision or under Medicare pursuant to subdivision (1) of this subsection.

Sec. 23. Subsection (c) of section 38a-530 of the 2020 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

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

Sec. 24. Subsection (b) of section 38a-530e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(b) No policy described in subsection (a) of this section shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for

the benefits and services required under said subsection (a), except that any such policy that uses a provider network may require cost-sharing when such benefits and services are rendered by an out-of-network provider. The cost-sharing limits imposed under this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section **[**38a-493**]** 38a-520, as amended by this act, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account **[**, as that term is used in**]** pursuant to Section 223 of **[**the**]** said Internal Revenue Code, **[**of 1986 or any subsequent corresponding internal revenue code of the United States,**]** as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable.

Sec. 25. Subsection (b) of section 38a-530f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(b) No policy described in subsection (a) of this section shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under said subsection. The provisions of this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section **[**38a-493**]** 38a-520, as amended by this act, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account, as that term is used in Section 223 of **[**the**]** said Internal Revenue Code, **[**of 1986 or any subsequent corresponding internal revenue code of the United States,**]** as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is

permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable. Nothing in this section shall preclude a policy that provides the coverage required under subsection (a) of this section and uses a provider network from imposing cost-sharing requirements for any benefit or service required under said subsection (a) that is delivered by an out-of-network provider.

Sec. 26. Subsection (c) of section 38a-550 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(c) The provisions of subsections (a) and (b) of this section shall not apply to a high deductible health plan as that term is used in subsection (f) of section 38a-520, as amended by this act.

| This act shall take effect as follows and shall amend the following sections: | | |
|---|---|---|
| Section 1 | *January 1, 2021* | 38a-492d |
| Sec. 2 | *January 1, 2021* | 38a-518d |
| Sec. 3 | *from passage* | New section |
| Sec. 4 | *from passage* | New section |
| Sec. 5 | *October 1, 2020* | 38a-493(f) |
| Sec. 6 | *October 1, 2020* | 38a-490a(b) |
| Sec. 7 | *October 1, 2020* | 38a-492k(b)(2) |
| Sec. 8 | *October 1, 2020* | 38a-492o(b) |
| Sec. 9 | *October 1, 2020* | 38a-492r(b) |
| Sec. 10 | *October 1, 2020* | 38a-492s(b) |
| Sec. 11 | *October 1, 2020* | 38a-492t(b)(3) |
| Sec. 12 | *October 1, 2020* | 38a-503(c) |
| Sec. 13 | *October 1, 2020* | 38a-503e(b) |
| Sec. 14 | *October 1, 2020* | 38a-503f(b) |
| Sec. 15 | *October 1, 2020* | 38a-511(c) |
| Sec. 16 | *October 1, 2020* | 38a-520(f) |
| Sec. 17 | *October 1, 2020* | 38a-516a(b) |
| Sec. 18 | *October 1, 2020* | 38a-518k(b)(2) |
| Sec. 19 | *October 1, 2020* | 38a-518o(b) |
| Sec. 20 | *October 1, 2020* | 38a-518r(b) |

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|---|---|---|
| Sec. 21 | *October 1, 2020* | 38a-518s(b) |
| Sec. 22 | *October 1, 2020* | 38a-518t(b)(3) |
| Sec. 23 | *October 1, 2020* | 38a-530(c) |
| Sec. 24 | *October 1, 2020* | 38a-530e(b) |
| Sec. 25 | *October 1, 2020* | 38a-530f(b) |
| Sec. 26 | *October 1, 2020* | 38a-550(c) |

***Statement of Purpose:***

To: (1) Expand required health insurance coverage for prescription drugs, equipment and supplies used to treat diabetes; (2) restrict cost-sharing for such drugs, equipment and supplies; (3) require licensed pharmacists to dispense such drugs, equipment and supplies without a prescription in certain circumstances; (4) require the Commissioner of Social Services to study and report regarding the feasibility of implementing a low-income diabetes assistance fund; and (5) make changes to various provisions of the general statutes concerning high deductible health plans to more closely conform to provisions of the Internal Revenue Code concerning health savings accounts and medical savings accounts.

***[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.]***