General Assembly

Raised Bill No. 337

February Session, 2020

LCO No. **2043**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING HIGH DEDUCTIBLE HEALTH PLANS, QUALIFIED HEALTH PLANS AND DISCRIMINATION AGAINST PERSONS ON THE BASIS OF SEXUAL ORIENTATION AND GENDER IDENTITY.

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

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 Section 38a-1 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2021*):

Terms used in this title and sections 2 and 3 of this act, unless it appears from the context to the contrary, shall have a scope and meaning as set forth in this section.

(1) "Affiliate" or "affiliated" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with another person.

(2) "Alien insurer" means any insurer that has been chartered by or organized or constituted within or under the laws of any jurisdiction or country without the United States.

(3) "Annuities" means all agreements to make periodical payments where the making or continuance of all or some of the series of the payments, or the amount of the payment, is dependent upon the continuance of human life or is for a specified term of years. This definition does not apply to payments made under a policy of life insurance.

(4) "Commissioner" means the Insurance Commissioner.

(5) "Control", "controlled by" or "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with the person.

(6) "Domestic insurer" means any insurer that has been chartered by, incorporated, organized or constituted within or under the laws of this state.

(7) "Domestic surplus lines insurer" means any domestic insurer that has been authorized by the commissioner to write surplus lines insurance.

(8) "Foreign country" means any jurisdiction not in any state, district or territory of the United States.

(9) "Foreign insurer" means any insurer that has been chartered by or organized or constituted within or under the laws of another state or a territory of the United States.

(10) "Insolvency" or "insolvent" means, for any insurer, that it is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of: (A) Capital and surplus required by law for its organization and continued operation; or (B) the total par or stated value of its authorized and issued capital stock. For purposes of this subdivision "liabilities" shall include but not

be limited to reserves required by statute or by regulations adopted by the commissioner in accordance with the provisions of chapter 54 or specific requirements imposed by the commissioner upon a subject company at the time of admission or subsequent thereto.

(11) "Insurance" means any agreement to pay a sum of money, provide services or any other thing of value on the happening of a particular event or contingency or to provide indemnity for loss in respect to a specified subject by specified perils in return for a consideration. In any contract of insurance, an insured shall have an interest which is subject to a risk of loss through destruction or impairment of that interest, which risk is assumed by the insurer and such assumption shall be part of a general scheme to distribute losses among a large group of persons bearing similar risks in return for a ratable contribution or other consideration.

(12) "Insurer" or "insurance company" includes any person or combination of persons doing any kind or form of insurance business other than a fraternal benefit society, and shall include a receiver of any insurer when the context reasonably permits.

(13) "Insured" means a person to whom or for whose benefit an insurer makes a promise in an insurance policy. The term includes policyholders, subscribers, members and beneficiaries. This definition applies only to the provisions of this title and does not define the meaning of this word as used in insurance policies or certificates.

(14) "Life insurance" means insurance on human lives and insurances pertaining to or connected with human life. The business of life insurance includes granting endowment benefits, granting additional benefits in the event of death by accident or accidental means, granting additional benefits in the event of the total and permanent disability of the insured, and providing optional methods of settlement of proceeds. Life insurance includes burial contracts to the extent provided by section 38a-464.

(15) "Mutual insurer" means any insurer without capital stock, the

managing directors or officers of which are elected by its members.

(16) "Person" means an individual, a corporation, a partnership, a limited liability company, an association, a joint stock company, a business trust, an unincorporated organization or other legal entity.

(17) "Policy" means any document, including attached endorsements and riders, purporting to be an enforceable contract, which memorializes in writing some or all of the terms of an insurance contract.

(18) "State" means any state, district, or territory of the United States.

(19) "Subsidiary" of a specified person means an affiliate controlled by the person directly, or indirectly through one or more intermediaries.

(20) "Unauthorized insurer" or "nonadmitted insurer" means an insurer that has not been granted a certificate of authority by the commissioner to transact the business of insurance in this state or an insurer transacting business not authorized by a valid certificate.

(21) "United States" means the United States of America, its territories and possessions, the Commonwealth of Puerto Rico and the District of Columbia.

Sec. 2. (NEW) (*Effective January 1, 2021*) (a) For the purposes of this section:

(1) "Health carrier" has the same meaning as provided in section 38a-1080 of the general statutes, as amended by this act;

(2) "High deductible health plan" has the same meaning as that term is used in subsection (f) of section 38a-493 of the general statutes, as amended by this act, and subsection (f) of section 38a-520 of the general statutes, as amended by this act; and

(3) "Qualified high deductible health plan" means a high deductible health plan that imposes an annual deductible that is not less than the

minimum amount necessary for the high deductible health plan to qualify as a high deductible health plan, regardless of whether the high deductible health plan (A) 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, or (B) caps annual out-of-pocket expenses in the amount specified by the Internal Revenue Service, or any successor agency, for high deductible health plans.

(b) Notwithstanding any provision of the general statutes, each health carrier that delivers, issues for delivery, renews, amends or continues a qualified high deductible health plan in this state on or after January 1, 2021, shall apply the annual deductible for such qualified high deductible health plan on a policy year basis.

(c) The provisions of subsection (b) of this section shall apply to a qualified high deductible health plan to the maximum extent permitted by federal law, except if the qualified high deductible health 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 shall apply to the maximum extent that does not disqualify such account for the deductions allowed under said sections.

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

Sec. 3. (NEW) (*Effective January 1, 2021*) Each insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity that delivers, issues for delivery,

renews, amends or continues an individual or group health insurance policy in this state on or after January 1, 2021, that provides coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes shall require that each health care provider that provides a covered benefit to an insured and collects a coinsurance, copayment, deductible or other out-of-pocket expense from the insured under such policy for such covered benefit in an amount that exceeds the amount allowed under such policy shall, not later than three business days after such health care provider receives reimbursement for such covered benefit under such policy, issue a refund to the insured for such excess amount.

Sec. 4. Section 38a-1080 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2020*):

For purposes of sections 38a-1080 to 38a-1093, inclusive, and section 5 of this act:

(1) "Board" means the board of directors of the Connecticut Health Insurance Exchange;

(2) "Commissioner" means the Insurance Commissioner;

(3) "Exchange" means the Connecticut Health Insurance Exchange established pursuant to section 38a-1081;

(4) "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act, P.L. 111-152, as both may be amended from time to time, and regulations adopted thereunder;

(5) (A) "Health benefit plan" means an insurance policy or contract offered, delivered, issued for delivery, renewed, amended or continued in the state by a health carrier to provide, deliver, pay for or reimburse any of the costs of health care services.

(B) "Health benefit plan" does not include:

(i) Coverage of the type specified in subdivisions (5), (6), (7), (8), (9), (14), (15) and (16) of section 38a-469 or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation insurance;

(v) Automobile medical payment insurance;

(vi) Credit insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, under which benefits for health care services are secondary or incidental to other insurance benefits.

(C) "Health benefit plan" does not include the following benefits if they are provided under a separate insurance policy, certificate or contract or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

(ii) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof; or

(iii) Other similar, limited benefits specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time;

(iv) Other supplemental coverage, similar to coverage of the type specified in subdivisions (9) and (14) of section 38a-469, provided under a group health plan.

(D) "Health benefit plan" does not include coverage of the type specified in subdivisions (3) and (13) of section 38a-469 or other fixed indemnity insurance if (i) such coverage is provided under a separate insurance policy, certificate or contract, (ii) there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and (iii) the benefits are paid with respect to an event without regard to whether benefits were also provided under any group health plan maintained by the same plan sponsor;

(6) "Health care services" has the same meaning as provided in section 38a-478;

(7) "Health carrier" means an insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity subject to the insurance laws and regulations of the state or the jurisdiction of the commissioner that contracts or offers to contract to provide, deliver, pay for or reimburse any of the costs of health care services;

(8) "Internal Revenue Code" means the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time;

(9) "Person" has the same meaning as provided in section 38a-1, as amended by this act;

(10) "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with subsection (e) of section 38a-1086;

(11) "Qualified employer" has the same meaning as provided in Section 1312 of the Affordable Care Act;

(12) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in Section 1311(c) of the Affordable Care Act and section 38a-1086;

(13) "Qualified individual" has the same meaning as provided in Section 1312 of the Affordable Care Act;

(14) "Secretary" means the Secretary of the United States Department of Health and Human Services;

(15) "Small employer" has the same meaning as provided in section 38a-564.

Sec. 5. (NEW) (*Effective July 1, 2020*) (a) Notwithstanding any provision of the general statutes and to the extent permitted by federal law, each qualified health plan that is offered through the exchange at a silver level of coverage for a plan year beginning on or after January 1, 2021, shall provide coverage for the following benefits:

(1) Angiotensin converting enzyme inhibitors for an enrollee who is diagnosed with congestive heart failure, diabetes or coronary artery disease by a licensed health care provider who is acting within such health care provider's scope of practice;

(2) Anti-resorptive therapy for an enrollee who is diagnosed with osteoporosis or osteopenia by a licensed health care provider who is acting within such health care provider's scope of practice;

(3) Beta-adrenergic blocking agents for an enrollee who is diagnosed with congestive heart failure or coronary artery disease by a licensed health care provider who is acting within such health care provider's scope of practice;

(4) Blood pressure monitors for an enrollee who is diagnosed with hypertension by a licensed health care provider who is acting within such health care provider's scope of practice;

(5) Inhaled corticosteroids and peak flow meters for an enrollee who is diagnosed with asthma by a licensed health care provider who is acting within such health care provider's scope of practice;

(6) Insulin and other glucose lowering agents, retinopathy screening,

glucometers and hemoglobin A1c testing for an enrollee who is diagnosed with diabetes by a licensed health care provider who is acting within such health care provider's scope of practice;

(7) International normalized ratio testing for an enrollee who is diagnosed with liver disease or a bleeding disorder by a licensed health care provider who is acting within such health care provider's scope of practice;

(8) Low density lipoprotein testing for an enrollee who is diagnosed with heart disease by a licensed health care provider who is acting within such health care provider's scope of practice;

(9) Selective serotonin reuptake inhibitors for an enrollee who is diagnosed with depression by a licensed health care provider who is acting within such health care provider's scope of practice; and

(10) Statins for an enrollee who is diagnosed with heart disease or diabetes by a licensed health care provider who is acting within such health care provider's scope of practice.

(b) Notwithstanding any provision of the general statutes and to the extent permitted by federal law, each qualified health plan described in subsection (a) of this section shall:

(1) Have a minimum actuarial value of at least seventy per cent; and

(2) Provide enrollees with access to the broadest provider network available under qualified health plans offered by the health carrier through the exchange.

Sec. 6. Section 38a-447 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

No life insurance company doing business in this state may: (1) Make any distinction or discrimination between persons on the basis of race, sexual orientation or gender identity as to the premiums or rates charged for policies upon the lives of such persons; (2) demand or

require greater premiums from persons of one race, sexual orientation or gender identity than such as are at that time required by that company from persons of another race, sexual orientation or gender identity of the same age, sex, general condition of health and hope of longevity; or (3) make or require any rebate, diminution or discount on the basis of race, sexual orientation or gender identity upon the sum to be paid on any policy in case of the death of any person insured, nor insert in the policy any condition, nor make any stipulation whereby such person insured shall bind **[**himself, his heirs,**]** such person, such person's heirs, executors, administrators or assigns to accept any sum less than the full value or amount of such policy, in case of a claim accruing thereon by reason of the death of such person insured, other than such as are imposed upon all persons in similar cases; and each such stipulation or condition so made or inserted shall be void.

Sec. 7. 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. 8. 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. 9. 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. 10. 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. 11. 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. 12. 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. 13. 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. 14. 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. 15. 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. 16. 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. 17. 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. 18. 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. 19. 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. 20. 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. 21. 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. 22. 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. 23. 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. 24. 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. 25. 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. 26. 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. 27. 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. 28. 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-1
Sec. 2	*January 1, 2021*	New section
Sec. 3	*January 1, 2021*	New section
Sec. 4	*July 1, 2020*	38a-1080
Sec. 5	*July 1, 2020*	New section
Sec. 6	*October 1, 2020*	38a-447
Sec. 7	*October 1, 2020*	38a-493(f)
Sec. 8	*October 1, 2020*	38a-490a(b)
Sec. 9	*October 1, 2020*	38a-492k(b)(2)
Sec. 10	*October 1, 2020*	38a-492o(b)
Sec. 11	*October 1, 2020*	38a-492r(b)
Sec. 12	*October 1, 2020*	38a-492s(b)
Sec. 13	*October 1, 2020*	38a-492t(b)(3)
Sec. 14	*October 1, 2020*	38a-503(c)
Sec. 15	*October 1, 2020*	38a-503e(b)
Sec. 16	*October 1, 2020*	38a-503f(b)
Sec. 17	*October 1, 2020*	38a-511(c)
Sec. 18	*October 1, 2020*	38a-520(f)
Sec. 19	*October 1, 2020*	38a-516a(b)
Sec. 20	*October 1, 2020*	38a-518k(b)(2)
Sec. 21	*October 1, 2020*	38a-518o(b)
Sec. 22	*October 1, 2020*	38a-518r(b)
Sec. 23	*October 1, 2020*	38a-518s(b)
Sec. 24	*October 1, 2020*	38a-518t(b)(3)
Sec. 25	*October 1, 2020*	38a-530(c)
Sec. 26	*October 1, 2020*	38a-530e(b)
Sec. 27	*October 1, 2020*	38a-530f(b)
Sec. 28	*October 1, 2020*	38a-550(c)

Statement of Purpose:

To: (1) Require certain high deductible health plans to apply annual deductibles on a calendar year basis; (2) require certain health care providers to promptly refund excess cost-sharing payments for covered benefits; (3) require certain qualified health plans offered through the Connecticut Health Insurance Exchange to cover certain benefits, have a minimum actuarial value of at least seventy per cent and offer a broad provider network; (4) prohibit life insurers from discriminating against

persons on the basis of sexual orientation or gender identity; 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.]