



General Assembly

January Session, 2023

Raised Bill No. 976

LCO No. 3606



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING HEALTH COVERAGE MANDATES FOR CERTAIN HEALTH CONDITIONS.

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

1 Section 1. Section 38a-1 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective January 1, 2024*):

3 Terms used in this title and sections 2 to 46, inclusive, of this act,
4 unless it appears from the context to the contrary, shall have a scope and
5 meaning as set forth in this section.

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

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

12 (3) "Annuities" means all agreements to make periodical payments
13 where the making or continuance of all or some of the series of the
14 payments, or the amount of the payment, is dependent upon the

15 continuance of human life or is for a specified term of years. This
16 definition does not apply to payments made under a policy of life
17 insurance.

18 (4) "Commissioner" means the Insurance Commissioner.

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

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

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

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

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

36 (10) "Insolvency" or "insolvent" means, for any insurer, that it is
37 unable to pay its obligations when they are due, or when its admitted
38 assets do not exceed its liabilities plus the greater of: (A) Capital and
39 surplus required by law for its organization and continued operation;
40 or (B) the total par or stated value of its authorized and issued capital
41 stock. For purposes of this subdivision "liabilities" shall include but not
42 be limited to reserves required by statute or by regulations adopted by
43 the commissioner in accordance with the provisions of chapter 54 or
44 specific requirements imposed by the commissioner upon a subject

45 company at the time of admission or subsequent thereto.

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

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

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

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

73 (15) "Mutual insurer" means any insurer without capital stock, the
74 managing directors or officers of which are elected by its members.

75 (16) "Person" means an individual, a corporation, a partnership, a

76 limited liability company, an association, a joint stock company, a
77 business trust, an unincorporated organization or other legal entity.

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

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

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

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

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

92 Sec. 2. (NEW) (*Effective January 1, 2024*) Each individual health
93 insurance policy providing coverage of the type specified in
94 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
95 statutes delivered, issued for delivery, renewed, amended or continued
96 in this state on or after January 1, 2024, shall provide coverage for
97 treatment of postpartum depression.

98 Sec. 3. (NEW) (*Effective January 1, 2024*) 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, 2024, shall provide coverage for treatment of
103 postpartum depression.

104 Sec. 4. (NEW) (*Effective January 1, 2024*) Each individual health
105 insurance policy providing coverage of the type specified in

106 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
107 statutes delivered, issued for delivery, renewed, amended or continued
108 in this state on or after January 1, 2024, shall provide coverage for
109 physical therapy services rendered by a physical therapist licensed
110 under section 20-73 of the general statutes.

111 Sec. 5. (NEW) (*Effective January 1, 2024*) Each group health insurance
112 policy providing coverage of the type specified in subdivisions (1), (2),
113 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
114 issued for delivery, renewed, amended or continued in this state on or
115 after January 1, 2024, shall provide coverage for physical therapy
116 services rendered by a physical therapist licensed under section 20-73 of
117 the general statutes.

118 Sec. 6. (NEW) (*Effective January 1, 2024*) (a) For the purposes of this
119 section:

120 (1) "Body mass index" means the number calculated by dividing an
121 individual's weight in kilograms by the individual's height in meters
122 squared; and

123 (2) "Severe obesity" means a body mass index that is:

124 (A) Greater than forty; or

125 (B) Thirty-five or more if an individual has been diagnosed with a
126 comorbid disease or condition, including, but not limited to, a
127 cardiopulmonary condition, diabetes, hypertension or sleep apnea.

128 (b) Each individual health insurance policy providing coverage of the
129 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
130 of the general statutes delivered, issued for delivery, renewed, amended
131 or continued in this state on or after January 1, 2024, shall provide
132 coverage for:

133 (1) Each surgical procedure that is:

134 (A) Performed to treat severe obesity, including, but not limited to,

135 gastric bypass surgery, sleeve gastrectomy and duodenal switch
136 surgery;

137 (B) Recognized by the National Institutes of Health, American Society
138 for Metabolic and Bariatric Surgery and American College of Surgeons
139 as providing long-term weight loss; and

140 (C) Consistent with treatment guidelines issued by the National
141 Institutes of Health as applied to the insured; and

142 (2) Each outpatient prescription drug that is approved by the federal
143 Food and Drug Administration to treat severe obesity provided such
144 policy includes coverage for outpatient prescription drugs.

145 (c) The benefits required by subsection (b) of this section shall be
146 subject to the same terms and conditions that apply to all other benefits
147 covered under a policy that is subject to this section.

148 Sec. 7. (NEW) (*Effective January 1, 2024*) (a) For the purposes of this
149 section:

150 (1) "Body mass index" means the number calculated by dividing an
151 individual's weight in kilograms by the individual's height in meters
152 squared; and

153 (2) "Severe obesity" means a body mass index that is:

154 (A) Greater than forty; or

155 (B) Thirty-five or more if an individual has been diagnosed with a
156 comorbid disease or condition, including, but not limited to, a
157 cardiopulmonary condition, diabetes, hypertension or sleep apnea.

158 (b) Each group health insurance policy providing coverage of the
159 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
160 of the general statutes delivered, issued for delivery, renewed, amended
161 or continued in this state on or after January 1, 2024, shall provide
162 coverage for:

163 (1) Each surgical procedure that is:

164 (A) Performed to treat severe obesity, including, but not limited to,
165 gastric bypass surgery, sleeve gastrectomy and duodenal switch
166 surgery;

167 (B) Recognized by the National Institutes of Health, American Society
168 for Metabolic and Bariatric Surgery and American College of Surgeons
169 as providing long-term weight loss; and

170 (C) Consistent with treatment guidelines issued by the National
171 Institutes of Health as applied to the insured; and

172 (2) Each outpatient prescription drug that is approved by the federal
173 Food and Drug Administration to treat severe obesity provided such
174 policy includes coverage for outpatient prescription drugs.

175 (c) The benefits required by subsection (b) of this section shall be
176 subject to the same terms and conditions that apply to all other benefits
177 covered under a policy that is subject to this section.

178 Sec. 8. (NEW) (*Effective January 1, 2024*) (a) For the purposes of this
179 section:

180 (1) "Body mass index" means the number calculated by dividing a
181 Medicaid beneficiary's weight in kilograms by the Medicaid
182 beneficiary's height in meters squared; and

183 (2) "Severe obesity" means a body mass index that is:

184 (A) Greater than forty; or

185 (B) Thirty-five or more if a Medicaid beneficiary has been diagnosed
186 with a comorbid disease or condition, including, but not limited to, a
187 cardiopulmonary condition, diabetes, hypertension or sleep apnea.

188 (b) The Commissioner of Social Services shall provide Medicaid
189 reimbursement for:

190 (1) Each surgical procedure that is:

191 (A) Performed to treat severe obesity, including, but not limited to,
192 gastric bypass surgery, sleeve gastrectomy and duodenal switch
193 surgery;

194 (B) Recognized by the National Institutes of Health, American Society
195 for Metabolic and Bariatric Surgery and American College of Surgeons
196 as providing long-term weight loss; and

197 (C) Consistent with treatment guidelines issued by the National
198 Institutes of Health as applied to the Medicaid beneficiary; and

199 (2) Each outpatient prescription drug that is approved by the federal
200 Food and Drug Administration to treat severe obesity.

201 (c) The Commissioner of Social Services shall seek federal approval
202 of a Medicaid state plan amendment or Medicaid waiver, if necessary,
203 to implement the provisions of this section. Any submission of a
204 Medicaid state plan amendment or Medicaid waiver shall be in
205 accordance with the provisions of section 17b-8 of the general statutes.

206 (d) The Commissioner of Social Services shall adopt regulations, in
207 accordance with chapter 54 of the general statutes, to implement the
208 provisions of this section. The Commissioner of Social Services may
209 adopt policies or procedures to implement the provisions of this section
210 while in the process of adopting regulations, provided such policies or
211 procedures are posted on the Internet web site of the Department of
212 Social Services and on the eRegulations System prior to the adoption of
213 such policies or procedures.

214 Sec. 9. Subsection (a) of section 38a-503e of the general statutes is
215 repealed and the following is substituted in lieu thereof (*Effective January*
216 *1, 2024*):

217 (a) Each individual health insurance policy providing coverage of the
218 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
219 delivered, issued for delivery, renewed, amended or continued in this

220 state shall provide coverage for the following benefits and services:

221 (1) All contraceptive drugs, including, but not limited to, all over-the-
222 counter contraceptive drugs and emergency contraceptive drugs,
223 approved by the federal Food and Drug Administration. Such policy
224 may require an insured to use, prior to using a contraceptive drug
225 prescribed to the insured, a contraceptive drug that the federal Food and
226 Drug Administration has designated as therapeutically equivalent to
227 the contraceptive drug prescribed to the insured, unless otherwise
228 determined by the insured's prescribing health care provider.

229 (2) All contraceptive devices and products, excluding all over-the-
230 counter contraceptive devices and products, approved by the federal
231 Food and Drug Administration. Such policy may require an insured to
232 use, prior to using a contraceptive device or product prescribed to the
233 insured, a contraceptive device or product that the federal Food and
234 Drug Administration has designated as therapeutically equivalent to
235 the contraceptive device or product prescribed to the insured, unless
236 otherwise determined by the insured's prescribing health care provider.

237 (3) If a contraceptive drug, device or product described in subdivision
238 (1) or (2) of this subsection is prescribed by a licensed physician,
239 physician assistant or advanced practice registered nurse, a twelve-
240 month supply of such contraceptive drug, device or product dispensed
241 at one time or at multiple times, unless the insured or the insured's
242 prescribing health care provider requests less than a twelve-month
243 supply of such contraceptive drug, device or product. No insured shall
244 be entitled to receive a twelve-month supply of a contraceptive drug,
245 device or product pursuant to this subdivision more than once during
246 any policy year.

247 (4) All sterilization methods approved by the federal Food and Drug
248 Administration for women.

249 (5) Routine follow-up care concerning contraceptive drugs, devices
250 and products approved by the federal Food and Drug Administration.

251 (6) Counseling in (A) contraceptive drugs, devices and products
252 approved by the federal Food and Drug Administration, and (B) the
253 proper use of contraceptive drugs, devices and products approved by
254 the federal Food and Drug Administration.

255 Sec. 10. Subsection (a) of section 38a-530e of the general statutes is
256 repealed and the following is substituted in lieu thereof (*Effective January*
257 *1, 2024*):

258 (a) Each group health insurance policy providing coverage of the type
259 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
260 delivered, issued for delivery, renewed, amended or continued in this
261 state shall provide coverage for the following benefits and services:

262 (1) All contraceptive drugs, including, but not limited to, all over-the-
263 counter contraceptive drugs and emergency contraceptive drugs,
264 approved by the federal Food and Drug Administration. Such policy
265 may require an insured to use, prior to using a contraceptive drug
266 prescribed to the insured, a contraceptive drug that the federal Food and
267 Drug Administration has designated as therapeutically equivalent to
268 the contraceptive drug prescribed to the insured, unless otherwise
269 determined by the insured's prescribing health care provider.

270 (2) All contraceptive devices and products, excluding all over-the-
271 counter contraceptive devices and products, approved by the federal
272 Food and Drug Administration. Such policy may require an insured to
273 use, prior to using a contraceptive device or product prescribed to the
274 insured, a contraceptive device or product that the federal Food and
275 Drug Administration has designated as therapeutically equivalent to
276 the contraceptive device or product prescribed to the insured, unless
277 otherwise determined by the insured's prescribing health care provider.

278 (3) If a contraceptive drug, device or product described in subdivision
279 (1) or (2) of this subsection is prescribed by a licensed physician,
280 physician assistant or advanced practice registered nurse, a twelve-
281 month supply of such contraceptive drug, device or product dispensed
282 at one time or at multiple times, unless the insured or the insured's

283 prescribing health care provider requests less than a twelve-month
284 supply of such contraceptive drug, device or product. No insured shall
285 be entitled to receive a twelve-month supply of a contraceptive drug,
286 device or product pursuant to this subdivision more than once during
287 any policy year.

288 (4) All sterilization methods approved by the federal Food and Drug
289 Administration for women.

290 (5) Routine follow-up care concerning contraceptive drugs, devices
291 and products approved by the federal Food and Drug Administration.

292 (6) Counseling in (A) contraceptive drugs, devices and products
293 approved by the federal Food and Drug Administration, and (B) the
294 proper use of contraceptive drugs, devices and products approved by
295 the federal Food and Drug Administration.

296 Sec. 11. (NEW) (*Effective January 1, 2024*) Each individual health
297 insurance policy providing coverage of the type specified in
298 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
299 statutes delivered, issued for delivery, renewed, amended or continued
300 in this state on or after January 1, 2024, shall provide coverage for: (1)
301 Motorized wheelchairs, including, but not limited to, used motorized
302 wheelchairs; (2) repairs to motorized wheelchairs; and (3) replacement
303 batteries for motorized wheelchairs.

304 Sec. 12. (NEW) (*Effective January 1, 2024*) Each group health insurance
305 policy providing coverage of the type specified in subdivisions (1), (2),
306 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
307 issued for delivery, renewed, amended or continued in this state on or
308 after January 1, 2024, shall provide coverage for: (1) Motorized
309 wheelchairs, including, but not limited to, used motorized wheelchairs;
310 (2) repairs to motorized wheelchairs; and (3) replacement batteries for
311 motorized wheelchairs.

312 Sec. 13. (NEW) (*Effective January 1, 2024*) Each individual health
313 insurance policy providing coverage of the type specified in

314 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
315 statutes delivered, issued for delivery, renewed, amended or continued
316 in this state on or after January 1, 2024, shall provide coverage for
317 medical foods for individuals diagnosed with phenylketonuria.

318 Sec. 14. (NEW) (*Effective January 1, 2024*) Each group health insurance
319 policy providing coverage of the type specified in subdivisions (1), (2),
320 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
321 issued for delivery, renewed, amended or continued in this state on or
322 after January 1, 2024, shall provide coverage for medical foods for
323 individuals diagnosed with phenylketonuria.

324 Sec. 15. (NEW) (*Effective January 1, 2024*) Each individual health
325 insurance policy providing coverage of the type specified in
326 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
327 statutes delivered, issued for delivery, renewed, amended or continued
328 in this state on or after January 1, 2024, shall provide coverage for: (1) A
329 unilateral cochlear implant, and unilateral cochlear implant surgery, for
330 an insured who has been diagnosed with unilateral hearing loss; and (2)
331 bilateral cochlear implants and bilateral cochlear implant surgery for an
332 insured who has been diagnosed with bilateral hearing loss.

333 Sec. 16. (NEW) (*Effective January 1, 2024*) Each group health insurance
334 policy providing coverage of the type specified in subdivisions (1), (2),
335 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
336 issued for delivery, renewed, amended or continued in this state on or
337 after January 1, 2024, shall provide coverage for: (1) A unilateral
338 cochlear implant, and unilateral cochlear implant surgery, for an
339 insured who has been diagnosed with unilateral hearing loss; and (2)
340 bilateral cochlear implants and bilateral cochlear implant surgery for an
341 insured who has been diagnosed with bilateral hearing loss.

342 Sec. 17. (NEW) (*Effective January 1, 2024*) Each individual health
343 insurance policy providing coverage of the type specified in
344 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
345 statutes delivered, issued for delivery, renewed, amended or continued

346 in this state on or after January 1, 2024, shall provide coverage for equine
347 therapy for an insured who is a veteran. For the purposes of this section,
348 "veteran" has the same meaning as provided in section 27-103 of the
349 general statutes.

350 Sec. 18. (NEW) (*Effective January 1, 2024*) Each group health insurance
351 policy providing coverage of the type specified in subdivisions (1), (2),
352 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
353 issued for delivery, renewed, amended or continued in this state on or
354 after January 1, 2024, shall provide coverage for equine therapy for an
355 insured who is a veteran. For the purposes of this section, "veteran" has
356 the same meaning as provided in section 27-103 of the general statutes.

357 Sec. 19. (NEW) (*Effective January 1, 2024*) Each individual health
358 insurance policy providing coverage of the type specified in
359 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
360 statutes delivered, issued for delivery, renewed, amended or continued
361 in this state on or after January 1, 2024, shall provide coverage to self-
362 employed farmers. For the purposes of this section, "farmer" means any
363 person engaged in agricultural production as a trade or business.

364 Sec. 20. (NEW) (*Effective January 1, 2024*) Each group health insurance
365 policy providing coverage of the type specified in subdivisions (1), (2),
366 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
367 issued for delivery, renewed, amended or continued in this state on or
368 after January 1, 2024, shall provide coverage to self-employed farmers.
369 For the purposes of this section, "farmer" means any person engaged in
370 agricultural production as a trade or business.

371 Sec. 21. (NEW) (*Effective January 1, 2024*) Each individual health
372 insurance policy providing coverage of the type specified in
373 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
374 statutes delivered, issued for delivery, renewed, amended or continued
375 in this state on or after January 1, 2024, shall provide coverage for peer
376 support services provided by certified peer support specialists on an
377 outpatient basis. The Commissioner of Public Health shall adopt

378 regulations, in accordance with chapter 54 of the general statutes, to
379 establish certification and education requirements for peer support
380 specialists.

381 Sec. 22. (NEW) (*Effective January 1, 2024*) Each group health insurance
382 policy providing coverage of the type specified in subdivisions (1), (2),
383 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
384 issued for delivery, renewed, amended or continued in this state on or
385 after January 1, 2024, shall provide coverage for peer support services
386 provided by certified peer support specialists on an outpatient basis.
387 The Commissioner of Public Health shall adopt regulations, in
388 accordance with chapter 54 of the general statutes, to establish
389 certification and education requirements for peer support specialists.

390 Sec. 23. Section 38a-504 of the general statutes is repealed and the
391 following is substituted in lieu thereof (*Effective January 1, 2024*):

392 (a) Each insurance company, hospital service corporation, medical
393 service corporation, health care center or fraternal benefit society that
394 delivers, issues for delivery, renews, amends or continues in this state
395 individual health insurance policies providing coverage of the type
396 specified in subdivisions (1), (2), (4), [(10),] (11) and (12) of section 38a-
397 469, shall provide coverage under such policies for the surgical removal
398 of tumors and treatment of leukemia, including outpatient
399 chemotherapy, reconstructive surgery, cost of any nondental prosthesis
400 including any maxillo-facial prosthesis used to replace anatomic
401 structures lost during treatment for head and neck tumors or additional
402 appliances essential for the support of such prosthesis, outpatient
403 chemotherapy following surgical procedure in connection with the
404 treatment of tumors, and a wig if prescribed by a licensed oncologist for
405 a patient who suffers hair loss as a result of chemotherapy. Such benefits
406 shall be subject to the same terms and conditions applicable to all other
407 benefits under such policies.

408 (b) Except as provided in subsection (c) of this section, the coverage
409 required by subsection (a) of this section shall provide at least a yearly

410 benefit of five hundred dollars for the surgical removal of tumors, five
411 hundred dollars for reconstructive surgery, five hundred dollars for
412 outpatient chemotherapy, three hundred fifty dollars for a wig and
413 three hundred dollars for a nondental prosthesis, except that for
414 purposes of the surgical removal of breasts due to tumors the yearly
415 benefit for such prosthesis shall be at least three hundred dollars for
416 each breast removed.

417 (c) The coverage required by subsection (a) of this section shall
418 provide benefits for the reasonable costs of reconstructive surgery on
419 each breast on which a mastectomy has been performed, and
420 reconstructive surgery on a nondiseased breast to produce a
421 symmetrical appearance. Such benefits shall be subject to the same
422 terms and conditions applicable to all other benefits under such policies.
423 For the purposes of this subsection, [reconstructive surgery]
424 "reconstructive surgery" includes, but is not limited to, augmentation
425 mammoplasty, reduction mammoplasty and mastopexy.

426 (d) (1) Each policy of the type specified in subsection (a) of this section
427 that provides coverage for intravenously administered and orally
428 administered anticancer medications used to kill or slow the growth of
429 cancerous cells that are prescribed by a prescribing practitioner, as
430 defined in section 20-571, shall provide coverage for orally administered
431 anticancer medications on a basis that is no less favorable than
432 intravenously administered anticancer medications.

433 (2) No insurance company, hospital service corporation, medical
434 service corporation, health care center or fraternal benefit society that
435 delivers, issues for delivery, renews, amends or continues in this state a
436 policy of the type specified in subsection (a) of this section shall
437 reclassify such anticancer medications or increase the coinsurance,
438 copayment, deductible or other out-of-pocket expense imposed under
439 such policy for such medications to achieve compliance with this
440 subsection.

441 (e) The coverage required by subsection (a) of this section shall

442 provide benefits for the reasonable costs of nipple reconstruction
443 surgery and nipple tattooing on each breast on which a breast
444 reconstructive surgery has been performed for a medically necessary
445 purpose, including, but not limited to, prophylactic mastectomies. Such
446 benefits shall be subject to the same terms and conditions applicable to
447 all other benefits under such policies. For the purposes of this
448 subsection, "reconstructive surgery" includes, but is not limited to,
449 augmentation mammoplasty, reduction mammoplasty and mastopexy.

450 Sec. 24. Section 38a-542 of the general statutes is repealed and the
451 following is substituted in lieu thereof (*Effective January 1, 2024*):

452 (a) Each insurance company, hospital service corporation, medical
453 service corporation, health care center or fraternal benefit society that
454 delivers, issues for delivery, renews, amends or continues in this state
455 group health insurance policies providing coverage of the type specified
456 in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 shall provide
457 coverage under such policies for treatment of leukemia, including
458 outpatient chemotherapy, reconstructive surgery, cost of any nondental
459 prosthesis, including any maxillo-facial prosthesis used to replace
460 anatomic structures lost during treatment for head and neck tumors or
461 additional appliances essential for the support of such prosthesis,
462 outpatient chemotherapy following surgical procedures in connection
463 with the treatment of tumors, a wig if prescribed by a licensed
464 oncologist for a patient who suffers hair loss as a result of
465 chemotherapy, and costs of removal of any breast implant which was
466 implanted on or before July 1, 1994, without regard to the purpose of
467 such implantation, which removal is determined to be medically
468 necessary. Such benefits shall be subject to the same terms and
469 conditions applicable to all other benefits under such policies.

470 (b) Except as provided in subsection (c) of this section, the coverage
471 required by subsection (a) of this section shall provide at least a yearly
472 benefit of one thousand dollars for the costs of removal of any breast
473 implant, five hundred dollars for the surgical removal of tumors, five
474 hundred dollars for reconstructive surgery, five hundred dollars for

475 outpatient chemotherapy, three hundred fifty dollars for a wig and
476 three hundred dollars for a nondental prosthesis, except that for
477 purposes of the surgical removal of breasts due to tumors the yearly
478 benefit for such prosthesis shall be at least three hundred dollars for
479 each breast removed.

480 (c) The coverage required by subsection (a) of this section shall
481 provide benefits for the reasonable costs of reconstructive surgery on
482 each breast on which a mastectomy has been performed, and
483 reconstructive surgery on a nondiseased breast to produce a
484 symmetrical appearance. Such benefits shall be subject to the same
485 terms and conditions applicable to all other benefits under such policies.
486 For the purposes of this subsection, [reconstructive surgery]
487 "reconstructive surgery" includes, but is not limited to, augmentation
488 mammoplasty, reduction mammoplasty and mastopexy.

489 (d) (1) Each policy of the type specified in subsection (a) of this section
490 that provides coverage for intravenously administered and orally
491 administered anticancer medications used to kill or slow the growth of
492 cancerous cells that are prescribed by a prescribing practitioner, as
493 defined in section 20-571, shall provide coverage for orally administered
494 anticancer medications on a basis that is no less favorable than
495 intravenously administered anticancer medications.

496 (2) No insurance company, hospital service corporation, medical
497 service corporation, health care center or fraternal benefit society that
498 delivers, issues for delivery, renews, amends or continues in this state a
499 policy of the type specified in subsection (a) of this section shall
500 reclassify such anticancer medications or increase the coinsurance,
501 copayment, deductible or other out-of-pocket expense imposed under
502 such policy for such medications to achieve compliance with this
503 subsection.

504 (e) The coverage required by subsection (a) of this section shall
505 provide benefits for the reasonable costs of nipple reconstruction
506 surgery and nipple tattooing on each breast on which a breast

507 reconstructive surgery has been performed for a medically necessary
508 purpose, including, but not limited to, prophylactic mastectomies. Such
509 benefits shall be subject to the same terms and conditions applicable to
510 all other benefits under such policies. For the purposes of this
511 subsection, "reconstructive surgery" includes, but is not limited to,
512 augmentation mammoplasty, reduction mammoplasty and mastopexy.

513 Sec. 25. Section 38a-492k of the general statutes is repealed and the
514 following is substituted in lieu thereof (*Effective January 1, 2024*):

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

526 (b) No such policy shall impose:

527 (1) A deductible for a procedure that a physician initially undertakes
528 as a screening or diagnostic colonoscopy or [a screening]
529 sigmoidoscopy; or

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

535 Sec. 26. Section 38a-518k of the general statutes is repealed and the
536 following is substituted in lieu thereof (*Effective January 1, 2024*):

537 (a) Each group health insurance policy providing coverage of the type
538 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
539 delivered, issued for delivery, amended, renewed or continued in this
540 state shall provide coverage for colorectal cancer screening and
541 diagnosis, including, but not limited to, (1) an annual fecal occult blood
542 test, and (2) colonoscopy, flexible sigmoidoscopy or radiologic imaging,
543 in accordance with the recommendations established by the American
544 Cancer Society, based on the ages, family histories and frequencies
545 provided in the recommendations. Except as specified in subsection (b)
546 of this section, benefits under this section shall be subject to the same
547 terms and conditions applicable to all other benefits under such policies.

548 (b) No such policy shall impose:

549 (1) A deductible for a procedure that a physician initially undertakes
550 as a screening or diagnostic colonoscopy or [a screening]
551 sigmoidoscopy; or

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

557 Sec. 27. (NEW) (*Effective January 1, 2024*) (a) As used in this section:

558 (1) "Experimental fertility procedure" means a procedure for which
559 the published medical evidence is not sufficient for the American
560 Society for Reproductive Medicine, its successor organization or a
561 comparable organization to regard the procedure as established medical
562 practice;

563 (2) "Fertility diagnostic care" means procedures, products,
564 medications and services intended to provide information and
565 counseling about an individual's fertility, including laboratory
566 assessments and imaging studies;

567 (3) "Fertility patient" means (A) an individual or a couple
568 experiencing infertility, (B) an individual or a couple who is at increased
569 risk of transmitting a serious inheritable genetic or chromosomal
570 abnormality to a child, (C) an individual unable to achieve a pregnancy
571 as an individual or with a partner because the individual or couple does
572 not have the necessary gametes to achieve a pregnancy, or (D) an
573 individual or couple for whom fertility preservation services are
574 medically necessary;

575 (4) "Fertility preservation services" (A) means procedures, products,
576 medications and services intended to preserve fertility, consistent with
577 established medical practice and professional guidelines published by
578 the American Society for Reproductive Medicine, its successor
579 organization or a comparable organization for an individual who has a
580 medical or genetic condition or who is expected to undergo treatment
581 that may directly or indirectly cause a risk of impairment of fertility, and
582 (B) includes, but is not limited to, the procurement and cryopreservation
583 of gametes, embryos and reproductive material, and storage from the
584 time of cryopreservation until the individual reaches the age of thirty,
585 or for a period of not less than five years, whichever is later;

586 (5) "Fertility treatment" means procedures, products, genetic testing,
587 medications and services intended to achieve pregnancy that result in a
588 live birth and that are provided in a manner consistent with established
589 medical practice and professional guidelines published by the American
590 Society for Reproductive Medicine, its successor organization or a
591 comparable organization;

592 (6) "Gamete" means a sperm or egg;

593 (7) "Infertility" means (A) the presence of a condition recognized by a
594 provider as a cause of loss or impairment of fertility, (B) a couple's
595 inability to achieve pregnancy after twelve months of unprotected
596 sexual intercourse when the couple has the necessary gametes to
597 achieve pregnancy, or (C) an individual's inability to achieve pregnancy
598 after twelve months of unprotected sexual intercourse due to such

599 individual's age;

600 (8) "Oocyte" means an ovum or egg cell before maturation; and

601 (9) "Religious employer" means an employer that is a "qualified
602 church-controlled organization", as defined in 26 USC 3121, or a church-
603 affiliated organization.

604 (b) Except as provided in subsections (e), (f) and (h) of this section,
605 each individual health insurance policy providing coverage of the type
606 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of
607 the general statutes, delivered, issued for delivery, amended, renewed
608 or continued in this state on or after January 1, 2024, shall provide
609 coverage for:

610 (1) Fertility diagnostic care;

611 (2) Fertility treatment if the enrollee is a fertility patient; and

612 (3) Fertility preservation services.

613 (c) A policy that provides coverage for the services required under
614 this section, may not:

615 (1) Impose any limitations on coverage solely on the basis of an
616 individual's age;

617 (2) Require that a pregnancy loss suffered during the twelve-month
618 period referenced in subparagraphs (B) and (C) of subdivision (7) of
619 subsection (a) of this section initiates a new time frame for determining
620 whether an individual or couple is experiencing infertility;

621 (3) Use any prior diagnosis or fertility treatment as a basis for
622 excluding, limiting or otherwise restricting the availability of coverage
623 required under this section;

624 (4) Impose any limitations on coverage required under this section
625 based on an individual's use of donor gametes, donor embryos or
626 surrogacy;

627 (5) Impose any copayments, deductibles, coinsurances, benefit
628 maximums, waiting periods or other limitations on coverage that are
629 different than any maternity benefits provided by the health insurance
630 policy;

631 (6) Impose any exclusions, limitations or other restrictions on
632 coverage of fertility medications that are different from those imposed
633 on any other prescription medications;

634 (7) Impose different limitations on coverage for, provide different
635 benefits to or impose different requirements on any class of persons
636 whose rights are protected pursuant to chapter 814c of the general
637 statutes; and

638 (8) Base any limitations imposed by the policy on anything other than
639 an individual's medical history and clinical guidelines adopted by the
640 policy.

641 (d) Any clinical guidelines used for a policy subject to the
642 requirements of this section shall (1) be based on current guidelines
643 developed by the American Society for Reproductive Medicine, its
644 successor organization or a comparable organization, (2) cite with
645 specificity any data or scientific reference relied upon, (3) be maintained
646 in written form, and (4) be made available to an individual in writing
647 upon request.

648 (e) A policy that provides coverage for the services required under
649 this section may:

650 (1) Limit such coverage to four completed oocyte retrievals, with
651 unlimited embryo transfers;

652 (2) Limit such coverage for intrauterine insemination to a lifetime
653 maximum benefit of six cycles;

654 (3) Limit coverage for in-vitro fertilization to those individuals who
655 have been unable to achieve or sustain a pregnancy to live birth through
656 less expensive and medically viable infertility treatment or procedures

657 covered under such policy; and

658 (4) Require that treatment or procedures that shall be covered as
659 provided in this section be performed at facilities that conform to the
660 standards and guidelines developed by the American Society of
661 Reproductive Medicine or the Society of Reproductive Endocrinology
662 and Infertility.

663 (f) Any insurance company, hospital service corporation, medical
664 service corporation or health care center may issue to a religious
665 employer an individual health insurance policy that excludes coverage
666 for methods of diagnosis and treatment for services required to be
667 covered under this section that are contrary to the religious employer's
668 bona fide religious tenets. Upon the written request of an individual
669 who states in writing that methods of diagnosis and treatment for
670 services required to be covered under this section are contrary to such
671 individual's religious or moral beliefs, any insurance company, hospital
672 service corporation, medical service corporation or health care center
673 may issue to or on behalf of the individual a policy or rider thereto that
674 excludes coverage for such methods.

675 (g) Any health insurance policy issued pursuant to subsection (b) of
676 this section shall provide written notice to each insured or prospective
677 insured the methods of diagnosis and treatment of infertility that are
678 excluded from coverage pursuant to this section. Such notice shall
679 appear, in not less than ten-point type, in the policy, application and
680 sales brochure for such policy.

681 (h) Any health insurance policy issued pursuant to subsection (b) of
682 this section shall not be required to provide coverage for:

683 (1) Any experimental fertility procedure; or

684 (2) Any nonmedical costs related to procuring gametes, donor
685 embryos or surrogacy services.

686 (i) Nothing in this section shall be construed to deny the coverage

687 required under this section to any individual who foregoes a particular
688 infertility treatment or procedure if the individual's physician
689 determines that such treatment or procedure is likely to be unsuccessful
690 or the individual seeks to use previously retrieved oocytes or embryos.

691 Sec. 28. (NEW) (*Effective January 1, 2024*) (a) As used in this section:

692 (1) "Experimental fertility procedure" means a procedure for which
693 the published medical evidence is not sufficient for the American
694 Society for Reproductive Medicine, its successor organization or a
695 comparable organization to regard the procedure as established medical
696 practice;

697 (2) "Fertility diagnostic care" means procedures, products,
698 medications and services intended to provide information and
699 counseling about an individual's fertility, including laboratory
700 assessments and imaging studies;

701 (3) "Fertility patient" means (A) an individual or a couple
702 experiencing infertility, (B) an individual or a couple who is at increased
703 risk of transmitting a serious inheritable genetic or chromosomal
704 abnormality to a child, (C) an individual unable to achieve a pregnancy
705 as an individual or with a partner because the individual or couple does
706 not have the necessary gametes to achieve a pregnancy, or (D) an
707 individual or couple for whom fertility preservation services are
708 medically necessary;

709 (4) "Fertility preservation services" (A) means procedures, products,
710 medications and services intended to preserve fertility, consistent with
711 established medical practice and professional guidelines published by
712 the American Society for Reproductive Medicine, its successor
713 organization or a comparable organization for an individual who has a
714 medical or genetic condition or who is expected to undergo treatment
715 that may directly or indirectly cause a risk of impairment of fertility, and
716 (B) includes, but is not limited to, the procurement and cryopreservation
717 of gametes, embryos and reproductive material, and storage from the
718 time of cryopreservation until the individual reaches the age of thirty,

719 or for a period of not less than five years, whichever is later;

720 (5) "Fertility treatment" means procedures, products, genetic testing,
721 medications and services intended to achieve pregnancy that result in a
722 live birth and that are provided in a manner consistent with established
723 medical practice and professional guidelines published by the American
724 Society for Reproductive Medicine, its successor organization or a
725 comparable organization;

726 (6) "Gamete" means a sperm or egg;

727 (7) "Infertility" means (A) the presence of a condition recognized by a
728 provider as a cause of loss or impairment of fertility, (B) a couple's
729 inability to achieve pregnancy after twelve months of unprotected
730 sexual intercourse when the couple has the necessary gametes to
731 achieve pregnancy, or (C) an individual's inability to achieve pregnancy
732 after twelve months of unprotected sexual intercourse due to such
733 individual's age;

734 (8) "Oocyte" means an ovum or egg cell before maturation; and

735 (9) "Religious employer" means an employer that is a "qualified
736 church-controlled organization", as defined in 26 USC 3121, or a church-
737 affiliated organization.

738 (b) Except as provided in subsections (e), (f) and (h) of this section,
739 each group health insurance policy providing coverage of the type
740 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of
741 the general statutes, delivered, issued for delivery, amended, renewed
742 or continued in this state on or after January 1, 2024, shall provide
743 coverage for:

744 (1) Fertility diagnostic care;

745 (2) Fertility treatment if the enrollee is a fertility patient; and

746 (3) Fertility preservation services.

747 (c) A policy that provides coverage for the services required under
748 this section, may not:

749 (1) Impose any limitations on coverage solely on the basis of an
750 individual's age;

751 (2) Require that a pregnancy loss suffered during the twelve-month
752 period referenced in subparagraphs (B) and (C) of subdivision (7) of
753 subsection (a) of this section initiates a new time frame for determining
754 whether an individual or couple is experiencing infertility;

755 (3) Use any prior diagnosis or fertility treatment as a basis for
756 excluding, limiting or otherwise restricting the availability of coverage
757 required under this section;

758 (4) Impose any limitations on coverage required under this section
759 based on an individual's use of donor gametes, donor embryos or
760 surrogacy;

761 (5) Impose any copayments, deductibles, coinsurances, benefit
762 maximums, waiting periods or other limitations on coverage that are
763 different than any maternity benefits provided by the health insurance
764 policy;

765 (6) Impose any exclusions, limitations or other restrictions on
766 coverage of fertility medications that are different from those imposed
767 on any other prescription medications;

768 (7) Impose different limitations on coverage for, provide different
769 benefits to or impose different requirements on any class of persons
770 whose rights are protected pursuant to chapter 814c of the general
771 statutes; and

772 (8) Base any limitations imposed by the policy on anything other than
773 an individual's medical history and clinical guidelines adopted by the
774 policy.

775 (d) Any clinical guidelines used for a policy subject to the

776 requirements of this section shall (1) be based on current guidelines
777 developed by the American Society for Reproductive Medicine, its
778 successor organization or a comparable organization, (2) cite with
779 specificity any data or scientific reference relied upon, (3) be maintained
780 in written form, and (4) be made available to an individual in writing
781 upon request.

782 (e) A policy that provides coverage for the services required under
783 this section may:

784 (1) Limit such coverage to four completed oocyte retrievals, with
785 unlimited embryo transfers;

786 (2) Limit such coverage for intrauterine insemination to a lifetime
787 maximum benefit of six cycles;

788 (3) Limit coverage for in-vitro fertilization to those individuals who
789 have been unable to achieve or sustain a pregnancy to live birth through
790 less expensive and medically viable infertility treatment or procedures
791 covered under such policy; and

792 (4) Require that treatment or procedures that shall be covered as
793 provided in this section be performed at facilities that conform to the
794 standards and guidelines developed by the American Society of
795 Reproductive Medicine or the Society of Reproductive Endocrinology
796 and Infertility.

797 (f) Any insurance company, hospital service corporation, medical
798 service corporation or health care center may issue to a religious
799 employer an individual health insurance policy that excludes coverage
800 for methods of diagnosis and treatment for services required to be
801 covered under this section that are contrary to the religious employer's
802 bona fide religious tenets. Upon the written request of an individual
803 who states in writing that methods of diagnosis and treatment for
804 services required to be covered under this section are contrary to such
805 individual's religious or moral beliefs, any insurance company, hospital
806 service corporation, medical service corporation or health care center

807 may issue to or on behalf of the individual a policy or rider thereto that
808 excludes coverage for such methods.

809 (g) Any health insurance policy issued pursuant to subsection (b) of
810 this section shall provide written notice to each insured or prospective
811 insured the methods of diagnosis and treatment of infertility that are
812 excluded from coverage pursuant to this section. Such notice shall
813 appear, in not less than ten-point type, in the policy, application and
814 sales brochure for such policy.

815 (h) Any health insurance policy issued pursuant to subsection (b) of
816 this section shall not be required to provide coverage for:

817 (1) Any experimental fertility procedure; or

818 (2) Any nonmedical costs related to procuring gametes, donor
819 embryos or surrogacy services.

820 (i) Nothing in this section shall be construed to deny the coverage
821 required under this section to any individual who foregoes a particular
822 infertility treatment or procedure if the individual's physician
823 determines that such treatment or procedure is likely to be unsuccessful
824 or the individual seeks to use previously retrieved oocytes or embryos.

825 Sec. 29. (NEW) (*Effective January 1, 2024*) (a) Each individual health
826 insurance policy providing coverage of the type specified in
827 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
828 statutes delivered, issued for delivery, renewed, amended or continued
829 in this state on or after January 1, 2024, shall provide coverage for not
830 less than one generic opioid antagonist and device. For purposes of this
831 section, "opioid antagonist" means naloxone hydrochloride or any other
832 similarly acting and equally safe drug approved by the federal Food and
833 Drug Administration for the treatment of a drug overdose.

834 (b) No policy described in subsection (a) of this section shall impose
835 a coinsurance, copayment, deductible or other out-of-pocket expense for
836 the generic opioid antagonist and device that such policy is required to

837 cover pursuant to subsection (a) of this section.

838 Sec. 30. (NEW) (*Effective January 1, 2024*) (a) Each group health
839 insurance policy providing coverage of the type specified in
840 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
841 statutes delivered, issued for delivery, renewed, amended or continued
842 in this state on or after January 1, 2024, shall provide coverage for not
843 less than one generic opioid antagonist and device. For purposes of this
844 section, "opioid antagonist" means naloxone hydrochloride or any other
845 similarly acting and equally safe drug approved by the federal Food and
846 Drug Administration for the treatment of a drug overdose.

847 (b) No policy described in subsection (a) of this section shall impose
848 a coinsurance, copayment, deductible or other out-of-pocket expense for
849 the generic opioid antagonist and device that such policy is required to
850 cover pursuant to subsection (a) of this section.

851 Sec. 31. (NEW) (*Effective January 1, 2024*) Each individual health
852 insurance policy providing coverage of the type specified in
853 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
854 statutes delivered, issued for delivery, renewed, amended or continued
855 in this state on or after January 1, 2024, shall provide coverage for the
856 purchase of any trained service animal that is specially trained to assist
857 blind, deaf or mobility impaired persons or persons with a disability
858 that is other than physical, including, but not limited to, anxiety
859 disorders and post-traumatic stress disorder, provided the insured's
860 treating health care provider certifies in writing that such trained service
861 animal is medically necessary. Any such trained service animal shall be
862 purchased from a nonprofit organization that is established for the
863 training of such service animals. For the purposes of this section,
864 "service animal" has the same meaning as provided in 28 CFR 35.104, as
865 amended from time to time, and includes a service animal in training.

866 Sec. 32. (NEW) (*Effective January 1, 2024*) Each group health insurance
867 policy providing coverage of the type specified in subdivisions (1), (2),
868 (4), (11) and (12) of section 38a-469 of the general statutes delivered,

869 issued for delivery, renewed, amended or continued in this state on or
870 after January 1, 2024, shall provide coverage for the purchase of any
871 trained service animal that is specially trained to assist blind, deaf or
872 mobility impaired persons or persons with a disability that is other than
873 physical, including, but not limited to, anxiety disorders and post-
874 traumatic stress disorder, provided the insured's treating health care
875 provider certifies in writing that such trained service animal is
876 medically necessary. Any such trained service animal shall be
877 purchased from a nonprofit organization that is established for the
878 training of such service animals. For the purposes of this section,
879 "service animal" has the same meaning as provided in 28 CFR 35.104, as
880 amended from time to time, and includes a service animal in training.

881 Sec. 33. (NEW) (*Effective January 1, 2024*) Each individual health
882 insurance policy providing coverage of the type specified in
883 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
884 statutes delivered, issued for delivery, renewed, amended or continued
885 in this state on or after January 1, 2024, shall provide coverage for
886 vaginal, cervical and uterine medical procedures, including, but not
887 limited to, loop electrosurgical excision procedure, colposcopy, ablation
888 and intrauterine device insertion.

889 Sec. 34. (NEW) (*Effective January 1, 2024*) Each group health insurance
890 policy providing coverage of the type specified in subdivisions (1), (2),
891 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
892 issued for delivery, renewed, amended or continued in this state on or
893 after January 1, 2024, shall provide coverage for vaginal, cervical and
894 uterine medical procedures, including, but not limited to, loop
895 electrosurgical excision procedure, colposcopy, ablation and
896 intrauterine device insertion.

897 Sec. 35. (NEW) (*Effective January 1, 2024*) (a) Each individual health
898 insurance policy providing coverage of the type specified in
899 subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the
900 general statutes delivered, issued for delivery, renewed, amended or
901 continued in this state on or after January 1, 2024, that includes coverage

902 for outpatient prescription drugs shall provide coverage for not less
903 than one epinephrine cartridge dual-pack injector. For the purposes of
904 this section and sections 36 and 38 of this act, "epinephrine cartridge
905 injector" means a dual-pack containing automatic, prefilled cartridge
906 injectors or similar automatic injectable equipment used to deliver
907 epinephrine in a standard dose for an emergency first aid response to
908 allergic reactions.

909 (b) No policy described in subsection (a) of this section shall impose
910 a coinsurance, copayment, deductible or other out-of-pocket expense for
911 the epinephrine cartridge injector that such policy is required to cover
912 pursuant to said subsection (a) in an amount that exceeds twenty-five
913 dollars. The provisions of this subsection shall apply to a high
914 deductible health plan, as that term is used in subsection (f) of section
915 38a-493 of the general statutes, to the maximum extent permitted by
916 federal law, except if such plan is used to establish a medical savings
917 account or an Archer MSA pursuant to Section 220 of the Internal
918 Revenue Code of 1986, or any subsequent corresponding internal
919 revenue code of the United States, as amended from time to time, or a
920 health savings account pursuant to Section 223 of said Internal Revenue
921 Code, as amended from time to time. The provisions of this subsection
922 shall apply to such high deductible health plans to the maximum extent
923 that (1) is permitted by federal law, and (2) does not disqualify such
924 account for the deduction allowed under Section 220 or 223, of the
925 Internal Revenue Code of 1986, as applicable.

926 Sec. 36. (NEW) (*Effective January 1, 2024*) (a) Each group health
927 insurance policy providing coverage of the type specified in
928 subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the
929 general statutes delivered, issued for delivery, renewed, amended or
930 continued in this state on or after January 1, 2024, that includes coverage
931 for outpatient prescription drugs shall provide coverage for not less
932 than one epinephrine cartridge injector.

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

935 the epinephrine cartridge injector that such policy is required to cover
936 pursuant to said subsection (a) in an amount that exceeds twenty-five
937 dollars. The provisions of this subsection shall apply to a high
938 deductible health plan, as that term is used in subsection (f) of section
939 38a-520 of the general statutes, to the maximum extent permitted by
940 federal law, except if such plan is used to establish a medical savings
941 account or an Archer MSA pursuant to Section 220 of the Internal
942 Revenue Code of 1986, or any subsequent corresponding internal
943 revenue code of the United States, as amended from time to time, or a
944 health savings account pursuant to Section 223 of said Internal Revenue
945 Code, as amended from time to time. The provisions of this subsection
946 shall apply to such high deductible health plans to the maximum extent
947 that (1) is permitted by federal law, and (2) does not disqualify such
948 account for the deduction allowed under Section 220 or 223, of said
949 Internal Revenue Code of 1986, as applicable.

950 Sec. 37. Section 38a-479000 of the general statutes is repealed and the
951 following is substituted in lieu thereof (*Effective January 1, 2024*):

952 For the purposes of this part and section 38 of this act:

953 (1) "Commissioner" means the Insurance Commissioner.

954 (2) "Department" means the Insurance Department.

955 (3) "Drug" has the same meaning as provided in section 21a-92.

956 (4) "Health care plan" means an individual or a group health
957 insurance policy that provides coverage of the types specified in
958 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 and includes
959 coverage for outpatient prescription drugs.

960 (5) "Health carrier" means an insurance company, health care center,
961 hospital service corporation, medical service corporation, fraternal
962 benefit society or other entity that delivers, issues for delivery, renews,
963 amends or continues a health care plan in this state.

964 (6) "Person" has the same meaning as provided in section 38a-1, as

965 amended by this act.

966 (7) "Pharmacist" has the same meaning as provided in section 38a-
967 479aaa.

968 (8) "Pharmacist services" has the same meaning as provided in section
969 38a-479aaa.

970 (9) "Pharmacy" has the same meaning as provided in section 38a-
971 479aaa.

972 (10) "Pharmacy benefits manager" or "manager" means any person
973 that administers the prescription drug, prescription device, pharmacist
974 services or prescription drug and device and pharmacist services
975 portion of a health care plan on behalf of a health carrier.

976 (11) (A) "Rebate" means a discount or concession, which affects the
977 price of an outpatient prescription drug, that a pharmaceutical
978 manufacturer directly provides to a (i) health carrier for an outpatient
979 prescription drug manufactured by the pharmaceutical manufacturer,
980 or (ii) pharmacy benefits manager after the manager processes a claim
981 from a pharmacy or a pharmacist for an outpatient prescription drug
982 manufactured by the pharmaceutical manufacturer.

983 (B) "Rebate" does not mean a bona fide service fee, as such term is
984 defined in Section 447.502 of Title 42 of the Code of Federal Regulations,
985 as amended from time to time.

986 (12) "Specialty drug" means a prescription outpatient specialty drug
987 covered under the Medicare Part D program established pursuant to
988 Public Law 108-173, the Medicare Prescription Drug, Improvement, and
989 Modernization Act of 2003, as amended from time to time, that exceeds
990 the specialty tier cost threshold established by the Centers for Medicare
991 and Medicaid Services.

992 Sec. 38. (NEW) (*Effective January 1, 2024*) On or after January 1, 2024,
993 each contract entered into between a health carrier and a pharmacy
994 benefits manager that requires the pharmacy benefits manager to

995 administer the prescription drug, prescription device, pharmacist
996 services or prescription drug and device and pharmacist services
997 portion of a health care plan on behalf of the health carrier shall, if the
998 pharmacy benefits manager utilizes a tiered prescription drug
999 formulary, require the pharmacy benefits manager to include not less
1000 than one covered epinephrine cartridge injector in the cost-sharing tier
1001 that imposes the lowest coinsurance, copayment, deductible or other
1002 out-of-pocket expense for covered prescription drugs.

1003 Sec. 39. (NEW) (*Effective January 1, 2024*) Each individual health
1004 insurance policy providing coverage of the type specified in
1005 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
1006 statutes delivered, issued for delivery, renewed, amended or continued
1007 in this state on or after January 1, 2024, shall provide coverage for rapid
1008 whole genome sequencing for any critically ill child (1) when ordered
1009 by such child's health care provider, and (2) when clinical criteria are
1010 met.

1011 Sec. 40. (NEW) (*Effective January 1, 2024*) Each group health insurance
1012 policy providing coverage of the type specified in subdivisions (1), (2),
1013 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
1014 issued for delivery, renewed, amended or continued in this state on or
1015 after January 1, 2024, shall provide coverage for rapid whole genome
1016 sequencing for any critically ill child (1) when ordered by such child's
1017 health care provider, and (2) when clinical criteria are met.

1018 Sec. 41. (NEW) (*Effective January 1, 2024*) Each individual health
1019 insurance policy providing coverage of the type specified in
1020 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
1021 statutes delivered, issued for delivery, renewed, amended or continued
1022 in this state on or after January 1, 2024, shall provide coverage for
1023 prenatal care, postpartum care and costs associated with neonatal
1024 intensive care unit stays.

1025 Sec. 42. (NEW) (*Effective January 1, 2024*) Each group health insurance
1026 policy providing coverage of the type specified in subdivisions (1), (2),

1027 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
1028 issued for delivery, renewed, amended or continued in this state on or
1029 after January 1, 2024, shall provide coverage for prenatal care,
1030 postpartum care and costs associated with neonatal intensive care unit
1031 stays.

1032 Sec. 43. (NEW) (*Effective January 1, 2024*) Each individual health
1033 insurance policy providing coverage of the type specified in
1034 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
1035 statutes delivered, issued for delivery, renewed, amended or continued
1036 in this state on or after January 1, 2024, shall provide coverage for
1037 gambling disorder treatment. For the purposes of this section,
1038 "gambling disorder" has the same meaning as provided in the most
1039 recent edition of the American Psychiatric Association's "Diagnostic and
1040 Statistical Manual of Mental Disorders".

1041 Sec. 44. (NEW) (*Effective January 1, 2024*) Each group health insurance
1042 policy providing coverage of the type specified in subdivisions (1), (2),
1043 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
1044 issued for delivery, renewed, amended or continued in this state on or
1045 after January 1, 2024, shall provide coverage for gambling disorder
1046 treatment. For the purposes of this section, "gambling disorder" has the
1047 same meaning as provided in the most recent edition of the American
1048 Psychiatric Association's "Diagnostic and Statistical Manual of Mental
1049 Disorders".

1050 Sec. 45. (NEW) (*Effective January 1, 2024*) (a) As used in this section:

1051 (1) "Biomarker" means a characteristic, including, but not limited to,
1052 a gene mutation or protein expression that can be objectively measured
1053 and evaluated as an indicator of normal biological processes, pathogenic
1054 processes or pharmacologic responses to a specific therapeutic
1055 intervention for a disease or condition.

1056 (2) "Biomarker testing" means the analysis of a patient's tissue, blood
1057 or other biospecimen for the presence of a biomarker, including, but not
1058 limited to, tests for a single substance, tests for multiple substances,

1059 diseases or conditions and whole genome sequencing.

1060 (b) Each individual health insurance policy providing coverage of the
 1061 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
 1062 of the general statutes delivered, issued for delivery, renewed, amended
 1063 or continued in this state on or after January 1, 2024, shall provide
 1064 coverage for biomarker testing for the purpose of diagnosis, treatment,
 1065 appropriate management or ongoing monitoring of an insured's disease
 1066 or condition.

1067 Sec. 46. (NEW) (*Effective January 1, 2024*) (a) As used in this section:

1068 (1) "Biomarker" means a characteristic, including, but not limited to,
 1069 a gene mutation or protein expression that can be objectively measured
 1070 and evaluated as an indicator of normal biological processes, pathogenic
 1071 processes or pharmacologic responses to a specific therapeutic
 1072 intervention for a disease or condition.

1073 (2) "Biomarker testing" means the analysis of a patient's tissue, blood
 1074 or other biospecimen for the presence of a biomarker, including, but not
 1075 limited to, tests for a single substance, tests for multiple substances,
 1076 diseases or conditions and whole genome sequencing.

1077 (b) Each group health insurance policy providing coverage of the
 1078 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
 1079 of the general statutes delivered, issued for delivery, renewed, amended
 1080 or continued in this state on or after January 1, 2024, shall provide
 1081 coverage for biomarker testing for the purpose of diagnosis, treatment,
 1082 appropriate management or ongoing monitoring of an insured's disease
 1083 or condition.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2024</i>	38a-1
Sec. 2	<i>January 1, 2024</i>	New section
Sec. 3	<i>January 1, 2024</i>	New section
Sec. 4	<i>January 1, 2024</i>	New section

Sec. 5	<i>January 1, 2024</i>	New section
Sec. 6	<i>January 1, 2024</i>	New section
Sec. 7	<i>January 1, 2024</i>	New section
Sec. 8	<i>January 1, 2024</i>	New section
Sec. 9	<i>January 1, 2024</i>	38a-503e(a)
Sec. 10	<i>January 1, 2024</i>	38a-530e(a)
Sec. 11	<i>January 1, 2024</i>	New section
Sec. 12	<i>January 1, 2024</i>	New section
Sec. 13	<i>January 1, 2024</i>	New section
Sec. 14	<i>January 1, 2024</i>	New section
Sec. 15	<i>January 1, 2024</i>	New section
Sec. 16	<i>January 1, 2024</i>	New section
Sec. 17	<i>January 1, 2024</i>	New section
Sec. 18	<i>January 1, 2024</i>	New section
Sec. 19	<i>January 1, 2024</i>	New section
Sec. 20	<i>January 1, 2024</i>	New section
Sec. 21	<i>January 1, 2024</i>	New section
Sec. 22	<i>January 1, 2024</i>	New section
Sec. 23	<i>January 1, 2024</i>	38a-504
Sec. 24	<i>January 1, 2024</i>	38a-542
Sec. 25	<i>January 1, 2024</i>	38a-492k
Sec. 26	<i>January 1, 2024</i>	38a-518k
Sec. 27	<i>January 1, 2024</i>	New section
Sec. 28	<i>January 1, 2024</i>	New section
Sec. 29	<i>January 1, 2024</i>	New section
Sec. 30	<i>January 1, 2024</i>	New section
Sec. 31	<i>January 1, 2024</i>	New section
Sec. 32	<i>January 1, 2024</i>	New section
Sec. 33	<i>January 1, 2024</i>	New section
Sec. 34	<i>January 1, 2024</i>	New section
Sec. 35	<i>January 1, 2024</i>	New section
Sec. 36	<i>January 1, 2024</i>	New section
Sec. 37	<i>January 1, 2024</i>	38a-479ooo
Sec. 38	<i>January 1, 2024</i>	New section
Sec. 39	<i>January 1, 2024</i>	New section
Sec. 40	<i>January 1, 2024</i>	New section
Sec. 41	<i>January 1, 2024</i>	New section
Sec. 42	<i>January 1, 2024</i>	New section
Sec. 43	<i>January 1, 2024</i>	New section
Sec. 44	<i>January 1, 2024</i>	New section
Sec. 45	<i>January 1, 2024</i>	New section

Sec. 46	January 1, 2024	New section
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Statement of Purpose:

To require certain health insurance coverage for individual and group health insurance policies in this state.

[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.]