General Assembly

Raised Bill No. 976

January Session, 2023

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:

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 Section 38a-1 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2024*):

Terms used in this title and sections 2 to 46, inclusive, 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, 2024*) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2024, shall provide coverage for treatment of postpartum depression.

Sec. 3. (NEW) (*Effective January 1, 2024*) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2024, shall provide coverage for treatment of postpartum depression.

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

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

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

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

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

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

(A) Greater than forty; or

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

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

(1) Each surgical procedure that is:

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

gastric bypass surgery, sleeve gastrectomy and duodenal switch surgery;

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

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

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

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

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

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

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

(A) Greater than forty; or

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

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

(1) Each surgical procedure that is:

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

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

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

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

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

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

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

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

(A) Greater than forty; or

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

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

(1) Each surgical procedure that is:

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

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

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

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

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

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

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

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

state shall provide coverage for the following benefits and services:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) No such policy shall impose:

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

(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.

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

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

(b) No such policy shall impose:

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

(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.

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

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

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

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

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

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

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

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

individual's age;

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

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

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

(1) Fertility diagnostic care;

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

(3) Fertility preservation services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

covered under such policy; and

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

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

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

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

(1) Any experimental fertility procedure; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Fertility diagnostic care;

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

(3) Fertility preservation services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Any experimental fertility procedure; or

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

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

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

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

cover pursuant to subsection (a) of this section.

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

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

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

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

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

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

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

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

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

(b) No policy described in subsection (a) of this section shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the epinephrine cartridge injector that such policy is required to cover pursuant to said subsection (a) in an amount that exceeds twenty-five dollars. 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 of the general statutes, 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 high deductible health plans to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under Section 220 or 223, of the Internal Revenue Code of 1986, as applicable.

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

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

the epinephrine cartridge injector that such policy is required to cover pursuant to said subsection (a) in an amount that exceeds twenty-five dollars. 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 of the general statutes, 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 high deductible health plans to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under Section 220 or 223, of said Internal Revenue Code of 1986, as applicable.

Sec. 37. Section 38a-479ooo of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2024*):

For the purposes of this part <u>and section 38 of this act</u>:

(1) "Commissioner" means the Insurance Commissioner.

(2) "Department" means the Insurance Department.

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

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

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

(6) "Person" has the same meaning as provided in section 38a-1<u>, as</u>

amended by this act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

diseases or conditions and whole genome sequencing.

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

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

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

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

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

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

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

Sec. 46	*January 1, 2024*	New section

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.]