

OFFICE OF LEGISLATIVE RESEARCH
PUBLIC ACT SUMMARY



PA 18-10—sHB 5210

Insurance and Real Estate Committee

AN ACT MANDATING INSURANCE COVERAGE OF ESSENTIAL HEALTH BENEFITS AND EXPANDING MANDATED HEALTH BENEFITS FOR WOMEN, CHILDREN AND ADOLESCENTS

SUMMARY: This act requires certain health insurance policies to cover 10 essential health benefits, which are the same benefits the federal Patient Protection and Affordable Care Act (ACA) (P.L. 111-148, as amended) requires most policies to cover. It authorizes the insurance commissioner to adopt related regulations.

The act also requires certain health insurance policies to cover specified benefits and services, including preventive health care services; immunizations; and contraceptive drugs, devices, and products approved by the U.S. Food and Drug Administration (FDA). It generally requires the policies to cover these benefits and services in full with no cost sharing (such as coinsurance, copayments, or deductibles), except policies may impose cost sharing when an out-of-network provider renders the benefits and services. The act provides that high deductible plans designed to be compatible with federally qualified health savings accounts must comply with the cost-sharing prohibition to the extent permitted by federal law without disqualifying the account for the applicable federal tax deduction.

The ACA generally requires health insurance policies, except grandfathered ones, to cover these benefits and services with no cost sharing. (Grandfathered plans are those that existed before March 23, 2010 and that have not made significant coverage changes since.)

With respect to contraception, the act requires policies to cover a 12-month supply of an FDA-approved contraceptive drug, device, or product when prescribed by a licensed physician, physician assistant, or advanced practice registered nurse (APRN). The supply may be dispensed at one time or at multiple times, but an insured person is not entitled to receive a 12-month supply more than once per policy year.

The act generally applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. However, only individual policies and group policies covering small employers (up to 50 employees) must cover the 10 essential health benefits. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2019

OLR PUBLIC ACT SUMMARY

§§ 1, 2, 9 & 10 — ESSENTIAL HEALTH BENEFITS

Coverage Requirement

The act requires certain health insurance policies to cover 10 “essential health benefits” and prohibits policies from including annual or lifetime limits on their dollar value.

“Essential health benefits” are health care services and benefits that fall within the following categories:

1. ambulatory patient services;
2. emergency services;
3. hospitalization;
4. maternity and newborn health care;
5. mental health and substance use disorder services, including behavioral health treatment;
6. prescription drugs;
7. rehabilitative and habilitative services and devices;
8. laboratory services;
9. preventive and wellness services and chronic disease management; and
10. pediatric services, including oral and vision care.

Regulations

The act authorizes the insurance commissioner to adopt related regulations. The regulations may specify the health care services and benefits that fall within each essential health benefits category.

Application of Existing Law

Under the act, no existing state law regarding an ACA requirement supersedes this act’s essential health benefits requirement that provides greater protection to an insured person, unless the essential health benefits requirement prevents the application of an ACA requirement.

Applicability of Requirement

The act’s requirement to cover 10 essential health benefits (§§ 1 & 2) applies to individual and small employer group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan.

Its prohibition on annual or lifetime limits on the dollar value of essential health benefits (§§ 9 & 10) applies to these individual and small employer group policies and other group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover the expenses and services described above.

The act defines a “small employer” as an employer that employed an average of no more than 50 employees on business days in the preceding calendar year

OLR PUBLIC ACT SUMMARY

and employs at least one employee on the first day of the policy year. It excludes a sole proprietorship that employs only the sole proprietor or his or her spouse.

Under the act, an employer determines its number of employees by adding the number of full-time employees working at least 30 hours a week and the number of full-time equivalent (FTE) employees, then averaging the total for the calendar year. FTE employees are calculated for each month by dividing by 120 the total number of hours worked during the month by employees working less than 30 hours a week. If an employer did not exist in the preceding calendar year, it determines its number of employees based on the average number of employees it reasonably expects to employ in the calendar year.

§§ 3 & 4 — PREVENTIVE HEALTH SERVICES

Under the act, health insurance policies must cover the following benefits and services if they are evidence-based items and services recommended by the U.S. Preventive Services Task Force (USPSTF) with an “A” or “B” rating as of January 1, 2018:

1. domestic and interpersonal violence screening and counseling for women;
2. tobacco use intervention and cessation counseling for women who use tobacco;
3. well-woman visits for women younger than age 65;
4. breast cancer chemoprevention counseling for women at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by the woman's physician or APRN;
5. breast cancer risk assessment, genetic testing, and counseling;
6. screening for chlamydia, cervical and vaginal cancer, gonorrhea, and human immunodeficiency virus for sexually active women;
7. human papillomavirus (HPV) screening for women age 30 or older with normal cytology results;
8. sexually transmitted infections counseling for sexually active women;
9. anemia screening and folic acid supplements for pregnant women and women likely to become pregnant;
10. for pregnant women, hepatitis B screening, urinary tract and other infection screening, rhesus incompatibility screening, and follow-up rhesus incompatibility testing if the women are at increased risk for it;
11. syphilis screening for pregnant women and women at increased risk for syphilis;
12. breastfeeding support and counseling for women who are pregnant or breastfeeding;
13. breastfeeding supplies, including a breast pump, for women who are breastfeeding;
14. gestational diabetes screening for women who are 24- to 28-weeks pregnant and women at increased risk for gestational diabetes; and
15. osteoporosis screening for women age 60 or older.

The act also requires policies to cover the following benefits and services:

1. additional evidence-based items or services not described above that

OLR PUBLIC ACT SUMMARY

- receive an “A” or “B” rating from the USPSTF after January 1, 2018 and
2. evidence-informed preventive care and screenings for infants, children, and adolescents as provided for in guidelines supported by the U.S. Health Resources and Services Administration in effect as of January 1, 2018, and those effective after that date.

§§ 5 & 6 — IMMUNIZATIONS

The act requires health insurance policies that cover prescription drugs to also cover certain immunizations for children, adolescents, and adults. Specifically, they must cover immunizations (1) recommended by the American Academy of Pediatrics, American Academy of Family Physicians, and the American College of Obstetricians and Gynecologists and (2) that have, in effect, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. These include, for example, immunizations for influenza, meningitis, tetanus, HPV, hepatitis A and B, measles, mumps, rubella, and varicella.

§§ 7 & 8 — PREVENTIVE SERVICES FOR CHILDREN AND YOUTH

The act requires health insurance policies to cover preventive services for people age 21 or younger in accordance with the most recent edition of the American Academy of Pediatrics' *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* or any subsequent corresponding publication. These include services such as behavioral and developmental assessments; iron and fluoride supplements; and screening for autism, vision or hearing impairment, lipid disorders, and tuberculosis.

Existing law, unchanged by the act, requires group health insurance policies to cover preventive pediatric care for a child through age six (CGS § 38a-535).

§§ 11 & 12 — CONTRACEPTIVE BENEFITS AND SERVICES

Required Benefits and Services

Prior state law required health insurance policies that covered FDA-approved outpatient prescription drugs to also cover FDA-approved prescription contraceptive methods.

The act instead requires all affected health insurance policies to cover the following contraceptive benefits and services:

1. all FDA-approved contraceptive drugs, including over-the-counter ones;
2. all FDA-approved contraceptive devices and products, excluding over-the-counter ones;
3. all FDA-approved sterilization methods for women;
4. routine follow-up care concerning FDA-approved contraceptive drugs, devices, and products; and
5. counseling on FDA-approved contraceptive drugs, devices, and products and the proper use of them.

The act allows a policy to require an insured person, before using a prescribed

OLR PUBLIC ACT SUMMARY

contraceptive drug, device, or product, to use a drug, device, or product the FDA designates as therapeutically equivalent to the prescribed one, unless the prescribing provider determines otherwise.

Additionally, the act requires a policy to cover a 12-month supply of an FDA-approved contraceptive drug, device, or product prescribed by a licensed physician, physician assistant, or APRN, unless the insured person or prescribing provider requests less than a 12-month supply. A 12-month supply may be dispensed once or at multiple times, but an insured person is not entitled to receive a 12-month supply of a contraceptive drug, device, or product more than once per policy year.

Religious Exemption

Similar to prior law, the act allows religious employers and individuals to request in writing to their health carrier (e.g., insurer or HMO) that their policies not cover the contraceptive benefits and services described above if they are contrary to their bona fide religious tenets.

As under existing law, when a policy is written to exclude contraceptive benefits and services, the health carrier must include a notice of the exclusion in the policy, application, and sales brochure.

Also, under existing law, a religious exemption does not allow a policy to exclude coverage of drugs prescribed by a provider for non-contraceptive purposes. The act also extends this to apply to prescription contraceptive devices and products.