General Assembly

Raised Bill No. 6626

January Session, 2021

LCO No. **3769**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING REQUIRED HEALTH INSURANCE AND MEDICAID COVERAGE, AMBULANCE SERVICES AND COST TRANSPARENCY.

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

Section 1. (NEW) (*Effective January 1, 2022*) 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, 2022, 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. 2. (NEW) (*Effective January 1, 2022*) 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, 2022, 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. 3. (NEW) (*Effective January 1, 2022*) 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, 2022, 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. 4. (NEW) (*Effective January 1, 2022*) 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, 2022, 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. 5. (NEW) (*Effective January 1, 2022*) 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, 2022, shall provide coverage for medically necessary coronary calcium scan tests.

Sec. 6. (NEW) (*Effective January 1, 2022*) 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, 2022, shall provide coverage for medically necessary coronary calcium scan tests.

Sec. 7. (NEW) (*Effective January 1, 2022*) 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, 2022, shall provide coverage for genetic cystic fibrosis screenings for women.

Sec. 8. (NEW) (*Effective January 1, 2022*) 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, 2022, shall provide coverage for genetic cystic fibrosis screenings for women.

Sec. 9. (NEW) (*Effective January 1, 2022*) 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, 2022, shall provide coverage for the treatment of neurological conditions and diseases, including, but not limited to, physical therapy for the treatment of amyotrophic lateral sclerosis.

Sec. 10. (NEW) (*Effective January 1, 2022*) 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, 2022, shall provide coverage for the treatment of neurological conditions and diseases, including, but not limited to, physical therapy for the treatment of amyotrophic lateral sclerosis.

Sec. 11. (NEW) (*Effective January 1, 2022*) 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, 2022, 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. 12. (NEW) (*Effective January 1, 2022*) 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, 2022, 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. 13. (NEW) (*Effective January 1, 2022*) 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, 2022, 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. 14. (NEW) (*Effective January 1, 2022*) 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, 2022, 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. 15. (NEW) (*Effective January 1, 2022*) 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, 2022, shall provide coverage for audiologic, ophthalmologic and optometric care.

Sec. 16. (NEW) (*Effective January 1, 2022*) 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, 2022, shall provide coverage for audiologic, ophthalmologic and optometric care.

Sec. 17. (NEW) (*Effective July 1, 2021*) (a) The Commissioner of Social Services shall provide Medicaid reimbursement for audiologic, ophthalmologic and optometric care.

(b) The commissioner 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.

(c) The commissioner shall adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of this section. The commissioner 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. 18. Section 38a-492c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) For purposes of this section:

(1) "Inherited metabolic disease" includes (A) a disease for which newborn screening is required under section 19a-55; and (B) cystic fibrosis.

(2) "Low protein modified food product" means a product formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.

(3) "Amino acid modified preparation" means a product intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.

(4) "Specialized formula" means a nutritional formula **[**for children up to age twelve**]** that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal Food and Drug Administration and is intended for use solely under medical supervision in the dietary management of specific diseases.

(b) 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 amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases if the amino acid modified preparations or low protein modified food products are prescribed for the therapeutic treatment of inherited metabolic diseases and are administered under the direction of a physician.

(c) 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 specialized formulas when such specialized formulas are medically necessary for the treatment of a disease or condition and are administered under the direction of a physician.

(d) Such policy shall provide coverage for such preparations, food products and formulas on the same basis as outpatient prescription drugs.

Sec. 19. Section 38a-518c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) For purposes of this section:

(1) "Inherited metabolic disease" includes (A) a disease for which newborn screening is required under section 19a-55; and (B) cystic fibrosis.

(2) "Low protein modified food product" means a product formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.

(3) "Amino acid modified preparation" means a product intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.

(4) "Specialized formula" means a nutritional formula **[**for children up to age twelve**]** that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal Food and Drug Administration and is intended for use solely under medical supervision in the dietary management of specific diseases.

(b) 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 amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases if the amino acid modified preparations or low protein modified food products are prescribed for the therapeutic treatment of inherited metabolic diseases and are administered under the direction of a physician.

(c) 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 specialized formulas when such specialized formulas are medically necessary for the treatment of a disease or condition and are administered under the direction of a physician.

(d) Such policy shall provide coverage for such preparations, food products and formulas on the same basis as outpatient prescription drugs.

Sec. 20. Section 38a-492k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(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. 21. Section 38a-518k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(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. 22. Section 38a-498 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) (1) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for medically necessary ambulance services for persons covered by the policy at an in-network level, including an in-network level of cost-sharing. The hospital policy shall be primary if a person is covered under more than one policy. The

policy shall, as a minimum requirement, cover such services whenever any person covered by the contract is transported, when medically necessary, by ambulance: **[**to**]**

(A) To a hospital; **[**. Such**]** or

(B) From a hospital to such person's place of residence.

(2) Except as otherwise provided in this section, the benefits required under this section shall be subject to any policy provision which applies to other services covered by **[**such**]** the policies that are subject to this section. Notwithstanding any other provision of this section, such policies shall not be required to provide benefits in excess of the maximum allowable rate established by the Department of Public Health in accordance with section 19a-177.

(b) (1) Each such individual health insurance policy shall provide that any payment by such company, corporation or center for emergency ambulance services under coverage required by this section shall be paid directly to the ambulance provider rendering such service if such provider has complied with the provisions of this subsection and has not received payment for such service from any other source.

(2) Any ambulance provider submitting a bill for direct payment pursuant to this section shall **[**stamp the following statement on the face of each bill: "NOTICE: This bill subject to mandatory assignment pursuant to Connecticut general statutes".**]** indicate that such bill is subject to assignment by:

(A) Stamping such indication on such bill if such bill is submitted on paper; or

(B) Including such indication in such bill if such bill is submitted by electronic means.

(3) This subsection shall not apply to any transaction between an ambulance provider and an insurance company, hospital service corporation, medical service corporation, health care center or other

entity if the parties have entered into a contract providing for direct payment.

Sec. 23. Section 38a-525 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) (1) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for medically necessary ambulance services for persons covered by the policy at an in-network level, including an in-network level of cost-sharing. The hospital policy shall be primary if a person is covered under more than one policy. The policy shall, as a minimum requirement, cover such services whenever any person covered by the contract is transported, when medically necessary, by ambulance: **[**to**]**

(A) To a hospital; **[**. Such**]** or

(B) From a hospital to such person's place of residence.

(2) Except as otherwise provided in this section, the benefits required under this section shall be subject to any policy provision which applies to other services covered by **[**such**]** the policies that are subject to this section. Notwithstanding any other provision of this section, such policies shall not be required to provide benefits in excess of the maximum allowable rate established by the Department of Public Health in accordance with section 19a-177.

(b) (1) Each such group health insurance policy shall provide that any payment by such company, corporation or center for emergency ambulance services under coverage required by this section shall be paid directly to the ambulance provider rendering such service if such provider has complied with the provisions of this subsection and has not received payment for such service from any other source.

(2) Any ambulance provider submitting a bill for direct payment

pursuant to this section shall **[**stamp the following statement on the face of each bill: "NOTICE: This bill subject to mandatory assignment pursuant to Connecticut general statutes".**]** indicate that such bill is subject to assignment by:

(A) Stamping such indication on such bill if such bill is submitted on paper; or

(B) Including such indication in such bill if such bill is submitted by electronic means.

(3) This subsection shall not apply to any transaction between an ambulance provider and an insurance company, hospital service corporation, medical service corporation, health care center or other entity if the parties have entered into a contract providing for direct payment.

Sec. 24. (NEW) (*Effective October 1, 2021*) Not later than January 1, 2022, the Insurance Commissioner shall, within available appropriations, establish a program to advance breast health and breast cancer awareness, and promote greater understanding of the importance of early breast cancer detection, in this state. As part of the program, the commissioner shall, at a minimum, provide outreach to individuals, including, but not limited to, young women of color, in this state regarding the importance of breast health and early breast cancer detection.

Sec. 25. Section 38a-503 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) For purposes of this section:

(1) "Healthcare Common Procedure Coding System" or "HCPCS" means the billing codes used by Medicare and overseen by the federal Centers for Medicare and Medicaid Services that are based on the current procedural technology codes developed by the American Medical Association; and

(2) "Mammogram" means mammographic examination or breast tomosynthesis, including, but not limited to, a procedure with a HCPCS code of 77051, 77052, 77055, 77056, 77057, 77063, 77065, 77066, 77067, G0202, G0204, G0206 or G0279, or any subsequent corresponding code.

(b) **[**(1)**]** Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for:

(1) Diagnostic and screening mammograms **[**to any woman covered under the policy**]** for insureds that are at least equal to the following minimum requirements:

(A) A baseline mammogram, which may be provided by breast tomosynthesis at the option of the **[**woman covered under the policy**]** insured, for **[**any woman**]** an insured who is: **[**thirty-five**]**

(i) Thirty-five to thirty-nine years of age, inclusive; **[**and**]** or

(ii) Younger than thirty-five years of age if the insured is believed to be at increased risk for breast cancer due to:

(I) A family history of breast cancer;

(II) Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene variant that materially increases the insured's risk for breast cancer;

(III) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

(V) Other indications as determined by the insured's physician or advanced practice registered nurse; and

(B) **[**a mammogram**]** Mammograms, which may be provided by breast tomosynthesis at the option of the **[**woman covered under the policy**]** insured, every year for **[**any woman**]** an insured who is: **[**forty**]**

(i) Forty years of age or older; or

(ii) Younger than forty years of age if the insured is believed to be at increased risk for breast cancer due to:

(I) A family history, or prior personal history, of breast cancer;

(II) Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the insured's risk for breast cancer;

(III) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

(V) Other indications as determined by the insured's physician or advanced practice registered nurse.

(2) Such policy shall provide additional benefits for:

(A) Comprehensive **[**ultrasound screening**]** diagnostic and screening ultrasounds of an entire breast or breasts if:

(i) A mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or

(ii) **[**a woman**]** An insured is believed to be at increased risk for breast cancer due to:

(I) A family history, or prior personal history, of breast cancer; **[**,**]**

(II) **[**positive**]** Positive genetic testing **[**, or**]** for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the insured's risk for breast cancer;

(III) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

[(III) other**]** (V) Other indications as determined by **[**a woman's**]** the insured's physician or advanced practice registered nurse; **[**or (iii) such screening is recommended by a woman's treating physician for a woman who (I) is forty years of age or older, (II) has a family history or prior personal history of breast cancer, or (III) has a prior personal history of breast disease diagnosed through biopsy as benign;**]** and

(B) **[**Magnetic**]** Diagnostic and screening magnetic resonance imaging of an entire breast or breasts:

(i) **[**in**]** In accordance with guidelines established by the American Cancer Society for an insured who is thirty-five years of age or older; or

(ii) If an insured is younger than thirty-five years of age and believed to be at increased risk for breast cancer due to:

(I) A family history, or prior personal history, of breast cancer;

(II) Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the insured's risk for breast cancer;

(III) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest;

(IV) Prior or ongoing hormone treatment as part of a gender

reassignment; or

(V) Other indications as determined by the insured's physician or advanced practice registered nurse;

(C) Breast biopsies;

(D) Prophylactic mastectomies for an insured who is believed to be at increased risk for breast cancer due to positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the insured's risk for breast cancer; and

(E) Breast reconstructive surgery for an insured who has undergone:

(i) A prophylactic mastectomy; or

(ii) A mastectomy as part of the insured's course of treatment for breast cancer.

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

(d) Each mammography report provided to **[**a patient**]** an insured shall include information about breast density, based on the Breast

Imaging Reporting and Data System established by the American College of Radiology. Where applicable, such report shall include the following notice: "If your mammogram demonstrates that you have dense breast tissue, which could hide small abnormalities, you might benefit from supplementary screening tests, which can include a breast ultrasound screening or a breast MRI examination, or both, depending on your individual risk factors. A report of your mammography results, which contains information about your breast density, has been sent to your physician's or advanced practice registered nurse's office and you should contact your physician or advanced practice registered nurse if you have any questions or concerns about this report.".

Sec. 26. Section 38a-530 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) For purposes of this section:

(1) "Healthcare Common Procedure Coding System" or "HCPCS" means the billing codes used by Medicare and overseen by the federal Centers for Medicare and Medicaid Services that are based on the current procedural technology codes developed by the American Medical Association; and

(2) "Mammogram" means mammographic examination or breast tomosynthesis, including, but not limited to, a procedure with a HCPCS code of 77051, 77052, 77055, 77056, 77057, 77063, 77065, 77066, 77067, G0202, G0204, G0206 or G0279, or any subsequent corresponding code.

(b) **[**(1)**]** Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for:

(1) Diagnostic and screening mammograms **[**to any woman covered under the policy**]** for insureds that are at least equal to the following minimum requirements:

(A) A baseline mammogram, which may be provided by breast tomosynthesis at the option of the **[**woman covered under the policy**]** insured, for **[**any woman**]** an insured who is: **[**thirty-five**]**

(i) Thirty-five to thirty-nine years of age, inclusive; **[**and**]** or

(ii) Younger than thirty-five years of age if the insured is believed to be at increased risk for breast cancer due to:

(I) A family history of breast cancer;

(II) Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene variant that materially increases the insured's risk for breast cancer;

(III) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

(V) Other indications as determined by the insured's physician or advanced practice registered nurse; and

(B) **[**a mammogram**]** Mammograms, which may be provided by breast tomosynthesis at the option of the **[**woman covered under the policy**]** insured, every year for **[**any woman**]** an insured who is: **[**forty**]**

(i) Forty years of age or older; or

(ii) Younger than forty years of age if the insured is believed to be at increased risk for breast cancer due to:

(I) A family history, or prior personal history, of breast cancer;

(II) Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the insured's risk for breast cancer;

(III) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

(V) Other indications as determined by the insured's physician or advanced practice registered nurse.

(2) Such policy shall provide additional benefits for:

(A) Comprehensive **[**ultrasound screening**]** diagnostic and screening ultrasounds of an entire breast or breasts if:

(i) A mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or

(ii) **[**a woman**]** An insured is believed to be at increased risk for breast cancer due to:

(I) A family history, or prior personal history, of breast cancer; **[**,**]**

(II) **[**positive**]** Positive genetic testing **[**, or**]** for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the insured's risk for breast cancer;

(III) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

[(III) other**]** (V) Other indications as determined by **[**a woman's**]** the insured's physician or advanced practice registered nurse; **[**or (iii) such screening is recommended by a woman's treating physician for a woman who (I) is forty years of age or older, (II) has a family history or

prior personal history of breast cancer, or (III) has a prior personal history of breast disease diagnosed through biopsy as benign;**]** and

(B) **[**Magnetic**]** Diagnostic and screening magnetic resonance imaging of an entire breast or breasts:

(i) **[**in**]** In accordance with guidelines established by the American Cancer Society for an insured who is thirty-five years of age or older; or

(ii) If an insured is younger than thirty-five years of age and believed to be at increased risk for breast cancer due to:

(I) A family history, or prior personal history, of breast cancer;

(II) Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the insured's risk for breast cancer;

(III) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest;

(IV) Prior or ongoing hormone treatment as part of a gender reassignment; or

(V) Other indications as determined by the insured's physician or advanced practice registered nurse;

(C) Breast biopsies;

(D) Prophylactic mastectomies for an insured who is believed to be at increased risk for breast cancer due to positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the insured's risk for breast cancer; and

(E) Breast reconstructive surgery for an insured who has undergone:

(i) A prophylactic mastectomy; or

(ii) A mastectomy as part of the insured's course of treatment for breast cancer.

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

(d) Each mammography report provided to **[**a patient**]** an insured shall include information about breast density, based on the Breast Imaging Reporting and Data System established by the American College of Radiology. Where applicable, such report shall include the following notice: "If your mammogram demonstrates that you have dense breast tissue, which could hide small abnormalities, you might benefit from supplementary screening tests, which can include a breast ultrasound screening or a breast MRI examination, or both, depending on your individual risk factors. A report of your mammography results, which contains information about your breast density, has been sent to your physician's or advanced practice registered nurse's office and you should contact your physician or advanced practice registered nurse if you have any questions or concerns about this report.".

Sec. 27. Section 19a-193a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) Except as provided in subsection (c) of this section and subject to the provisions of sections 19a-177, 38a-498, as amended by this act, and 38a-525, as amended by this act, any person who receives emergency medical treatment services or transportation services from a licensed ambulance service, certified ambulance service or paramedic intercept service shall be liable to such ambulance service for the reasonable and necessary costs of providing such services, irrespective of whether such person agreed or consented to such liability.

(b) Except as provided in subsection (c) of this section, any person who receives medical services or transport services under nonemergency conditions from a mobile integrated health care program shall be liable to such mobile health care integrated program for the reasonable and necessary costs of providing such services.

(c) The provisions of this section shall not apply to any person who receives: **[**emergency**]**

(1) Emergency medical treatment services or transportation services from a licensed ambulance service, certified ambulance service, paramedic intercept service or mobile integrated health care program for an injury arising out of and in the course of such person's employment as defined in section 31-275; **[**.**]** or

(2) Transportation services from a licensed ambulance service, certified ambulance service or paramedic intercept service if such service reasonably believes that such transportation services are nonemergency transportation services, unless such service, before providing such transportation services:

(A) Discloses to such person the potential cost to such person if such transportation services are nonemergency transportation services; and

(B) Receives written consent from such person to provide such transportation services.

Sec. 28. (NEW) (*Effective October 1, 2021*) (a) As used in this section,

"mammogram" has the same meaning as provided in sections 38a-503 and 38a-530 of the general statutes, as amended by this act.

(b) Each health care provider who provides a mammogram to a patient shall provide to the patient:

(1) Advance notice disclosing whether a proposed test or examination to further investigate the results of the mammogram is:

(A) An elective test or examination; and

(B) Covered under the terms of the patient's health coverage; and

(2) An opportunity to determine whether the cost of a proposed test or examination to further investigate the results of the mammogram is covered under the terms of the patient's health coverage.

(c) The Commissioner of Public Health may adopt regulations, in consultation with the Insurance Commissioner and in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2022*	New section
Sec. 2	*January 1, 2022*	New section
Sec. 3	*January 1, 2022*	New section
Sec. 4	*January 1, 2022*	New section
Sec. 5	*January 1, 2022*	New section
Sec. 6	*January 1, 2022*	New section
Sec. 7	*January 1, 2022*	New section
Sec. 8	*January 1, 2022*	New section
Sec. 9	*January 1, 2022*	New section
Sec. 10	*January 1, 2022*	New section
Sec. 11	*January 1, 2022*	New section
Sec. 12	*January 1, 2022*	New section
Sec. 13	*January 1, 2022*	New section
Sec. 14	*January 1, 2022*	New section
Sec. 15	*January 1, 2022*	New section

Sec. 16	*January 1, 2022*	New section
Sec. 17	*July 1, 2021*	New section
Sec. 18	*January 1, 2022*	38a-492c
Sec. 19	*January 1, 2022*	38a-518c
Sec. 20	*January 1, 2022*	38a-492k
Sec. 21	*January 1, 2022*	38a-518k
Sec. 22	*January 1, 2022*	38a-498
Sec. 23	*January 1, 2022*	38a-525
Sec. 24	*October 1, 2021*	New section
Sec. 25	*January 1, 2022*	38a-503
Sec. 26	*January 1, 2022*	38a-530
Sec. 27	*January 1, 2022*	19a-193a
Sec. 28	*October 1, 2021*	New section

Statement of Purpose:

To: (1) Require certain individual and group health insurance policies to provide coverage for (A) motorized wheelchairs, including, but not limited to, (i) used motorized wheelchairs, (ii) repairs to motorized wheelchairs, and (iii) replacement batteries for motorized wheelchairs, (B) cochlear implants and cochlear implant surgery for insureds diagnosed with hearing loss, (C) medically necessary coronary calcium scan tests, (D) genetic cystic fibrosis screenings for women, (E) the treatment of neurological conditions and diseases, including, but not limited to, physical therapy for the treatment of amyotrophic lateral sclerosis, (F) equine therapy for veterans, (G) gambling disorder treatment, (H) audiologic, ophthalmologic and optometric care, and (I) specialized formulas for individuals twelve years of age or older; (2) require Medicaid coverage for audiologic, ophthalmologic and optometric care; (3) (A) modify required health insurance coverage for ambulance services to (i) include medically necessary transportation to a covered person's place of residence, and (ii) require that such benefits be provided at an in-network level, (B) provide for electronic notification of assignments of bills for ambulance services, and (C) require an ambulance provider to notify, and obtain consent from, a person before providing transportation services to the person if the provider reasonably believes that such services are not emergency services; (4) require the Insurance Commissioner to, within available appropriations, establish a program to advance breast health and breast cancer awareness, and promote greater understanding of the importance of early breast cancer detection, in this state; (5) expand required health insurance coverage under certain individual and group health insurance policies to include coverage for (A) colorectal cancer

diagnoses and related benefits, (B) breast health and breast cancer benefits regardless of sex, (C) diagnostic and screening (i) mammograms, including, but not limited to, (I) baseline mammograms for certain insureds younger than thirty-five years of age, and (II) annual mammograms for certain insureds younger than forty years of age, (ii) comprehensive breast ultrasounds, and (iii) magnetic resonance imaging of an entire breast or breasts, (D) breast biopsies, (E) prophylactic mastectomies for certain insureds, and (F) breast reconstructive surgery for certain insureds; and (6) (A) require a health care provider who provides a mammogram to a patient to provide to the patient (i) advance notice disclosing information regarding certain tests or examinations proposed to further investigate the results of the mammogram, and (ii) an opportunity to determine whether the cost of such proposed tests or examinations are covered under the terms of the patient's health coverage, and (B) authorize the Commissioner of Public Health, in consultation with the Insurance Commissioner, to adopt regulations.

[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.]