



House of Representatives

General Assembly

File No. 242

February Session, 2026

Substitute House Bill No. 5374

House of Representatives, March 30, 2026

The Committee on Insurance and Real Estate reported through REP. WOOD of the 29th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH COVERAGE MANDATES FOR CERTAIN HEALTH CONDITIONS.

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

1 Section 1. Section 38a-1 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective January 1, 2027*):

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

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

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

12 (3) "Annuities" means all agreements to make periodical payments

13 where the making or continuance of all or some of the series of the
14 payments, or the amount of the payment, is dependent upon the
15 continuance of human life or is for a specified term of years. This
16 definition does not apply to payments made under a policy of life
17 insurance.

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

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

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

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

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

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

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

44 specific requirements imposed by the commissioner upon a subject
45 company at the time of admission or subsequent thereto.

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

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

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

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

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

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

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

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

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

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

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

92 Sec. 2. (NEW) (*Effective January 1, 2027*) Each individual health
93 insurance policy providing coverage of the type specified in
94 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
95 statutes delivered, issued for delivery, renewed, amended or continued
96 in this state on or after January 1, 2027, shall provide coverage for the
97 treatment of Pediatric Autoimmune Neuropsychiatric Disorders
98 Associated with Streptococcal Infections and Pediatric Acute-onset
99 Neuropsychiatric Syndrome, including, but not limited to, the use of
100 intravenous immunoglobulin therapy.

101 Sec. 3. (NEW) (*Effective January 1, 2027*) Each group health insurance
102 policy providing coverage of the type specified in subdivisions (1), (2),
103 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
104 issued for delivery, renewed, amended or continued in this state on or
105 after January 1, 2027, shall provide coverage for the treatment of

106 Pediatric Autoimmune Neuropsychiatric Disorders Associated with
107 Streptococcal Infections and Pediatric Acute-onset Neuropsychiatric
108 Syndrome, including, but not limited to, the use of intravenous
109 immunoglobulin therapy.

110 Sec. 4. (NEW) (*Effective January 1, 2027*) (a) For the purposes of this
111 section, "scalp cooling system" means any device designed and intended
112 for repeated medical use to cool the human scalp to prevent or reduce
113 hair loss as a result of chemotherapy.

114 (b) (1) Each individual health insurance policy providing coverage of
115 the type specified in subdivisions (1), (2), (4), (11), (12) and (13) of section
116 38a-469 of the general statutes delivered, issued for delivery, renewed,
117 amended or continued in this state on or after January 1, 2027, that
118 provides coverage for chemotherapy shall provide coverage for scalp
119 cooling systems used in connection with such chemotherapy that is at
120 least equivalent to such coverage provided under Medicare.

121 (2) No policy described in subdivision (1) of this subsection shall
122 impose a coinsurance, copayment, deductible or other out-of-pocket
123 expense for any such scalp cooling system that is more restrictive than
124 that imposed on substantially all other benefits provided under such
125 policy, except that a high deductible health plan, as such term is used in
126 subsection (f) of section 38a-493 of the general statutes, shall not be
127 subject to the deductible limits set forth in this subdivision or under
128 Medicare pursuant to subdivision (1) of this subsection.

129 (c) Any individual health insurance policy may require prior
130 authorization for scalp cooling systems, provided such prior
131 authorization is required in the same manner and to the same extent as
132 is required for other covered benefits under such policy.

133 Sec. 5. (NEW) (*Effective January 1, 2027*) (a) For the purposes of this
134 section, "scalp cooling system" means any device designed and intended
135 for repeated medical use to cool the human scalp to prevent or reduce
136 hair loss as a result of chemotherapy.

137 (b) (1) Each group health insurance policy providing coverage of the
138 type specified in subdivisions (1), (2), (4), (11), (12) and (13) of section
139 38a-469 of the general statutes delivered, issued for delivery, renewed,
140 amended or continued in this state on or after January 1, 2027, that
141 provides coverage for chemotherapy shall provide coverage for scalp
142 cooling systems used in connection with such chemotherapy that is at
143 least equivalent to such coverage provided under Medicare.

144 (2) No policy described in subdivision (1) of this subsection shall
145 impose a coinsurance, copayment, deductible or other out-of-pocket
146 expense for any such scalp cooling system that is more restrictive than
147 that imposed on substantially all other benefits provided under such
148 policy, except that a high deductible health plan, as such term is used in
149 subsection (f) of section 38a-520 of the general statutes, shall not be
150 subject to the deductible limits set forth in this subdivision or under
151 Medicare pursuant to subdivision (1) of this subsection.

152 (c) Any group health insurance policy may require prior
153 authorization for scalp cooling systems, provided such prior
154 authorization is required in the same manner and to the same extent as
155 is required for other covered benefits under such policy.

156 Sec. 6. Subsection (a) of section 38a-492t of the general statutes is
157 repealed and the following is substituted in lieu thereof (*Effective January*
158 *1, 2027*):

159 (a) As used in this section, "prosthetic device" means an artificial limb
160 device to replace, in whole or in part, an arm or a leg, including a device
161 that contains a microprocessor if such microprocessor-equipped device
162 is determined by the insured's or enrollee's health care provider to be
163 medically necessary. ["Prosthetic device" does not include a device that
164 is designed exclusively for athletic purposes.]

165 Sec. 7. Subsection (a) of section 38a-518t of the general statutes is
166 repealed and the following is substituted in lieu thereof (*Effective January*
167 *1, 2027*):

168 (a) As used in this section, "prosthetic device" means an artificial limb
169 device to replace, in whole or in part, an arm or a leg, including a device
170 that contains a microprocessor if such microprocessor-equipped device
171 is determined by the insured's or enrollee's health care provider to be
172 medically necessary. ["Prosthetic device" does not include a device that
173 is designed exclusively for athletic purposes.]

174 Sec. 8. Subsection (a) of section 38a-509 of the general statutes is
175 repealed and the following is substituted in lieu thereof (*Effective January*
176 *1, 2027*):

177 (a) Subject to the limitations set forth in subsection (b) of this section
178 and except as provided in subsection (c) of this section, each individual
179 health insurance policy providing coverage of the type specified in
180 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered,
181 issued for delivery, amended, renewed or continued in this state on or
182 after January 1, 2018, shall provide coverage for the medically necessary
183 expenses for the diagnosis and treatment of infertility, including, but not
184 limited to, ovulation induction, intrauterine insemination, in-vitro
185 fertilization, uterine embryo lavage, embryo transfer, gamete intra-
186 fallopian transfer, zygote intra-fallopian transfer and low tubal ovum
187 transfer. For purposes of this section, "infertility" means [the condition
188 of an individual who is unable to conceive or produce conception or
189 sustain a successful pregnancy during a one-year period or such
190 treatment is medically necessary] (1) the inability to establish or carry a
191 pregnancy based on an individual's medical, sexual and reproductive
192 history, age, physical findings, diagnostic testing or any combination of
193 such factors, including, but not limited to, infertility arising from
194 disabilities or from medical treatments or conditions associated with a
195 disability, (2) the need for medical intervention, including, but not
196 limited to, the use of donor gametes, donor embryos or a gestational
197 surrogate, to establish a pregnancy either as an individual or with a
198 partner, (3) an individual's inability to establish a pregnancy or carry a
199 pregnancy to live birth after twelve months of unprotected sexual
200 intercourse when the individual and the individual's partner have the
201 necessary gametes to establish a pregnancy, provided a pregnancy loss

202 shall not restart the twelve-month period, and (4) an individual's
203 inability to establish a pregnancy or to carry a pregnancy to live birth
204 after six months of unprotected sexual intercourse due to the
205 individual's age when the individual and the individual's partner have
206 the necessary gametes to establish a pregnancy, provided a pregnancy
207 loss shall not restart the six-month period.

208 Sec. 9. Subdivision (4) of subsection (b) of section 38a-509 of the
209 general statutes is repealed and the following is substituted in lieu
210 thereof (*Effective January 1, 2027*):

211 (4) Limit coverage for in-vitro fertilization, gamete intra-fallopian
212 transfer, zygote intra-fallopian transfer and low tubal ovum transfer to
213 those individuals who [have been unable to conceive or produce
214 conception or sustain a successful] meet the definition of infertility and
215 have been unable to establish a pregnancy or carry a pregnancy through
216 less expensive and medically viable infertility treatment or procedures
217 covered under such policy. Nothing in this subdivision shall be
218 construed to deny the coverage required by this section to any
219 individual who foregoes a particular infertility treatment or procedure
220 if the individual's physician determines that such treatment or
221 procedure is likely to be unsuccessful; and

222 Sec. 10. Subsection (a) of section 38a-536 of the general statutes is
223 repealed and the following is substituted in lieu thereof (*Effective January*
224 *1, 2027*):

225 (a) Subject to the limitations set forth in subsection (b) of this section
226 and except as provided in subsection (c) of this section, each group
227 health insurance policy providing coverage of the type specified in
228 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered,
229 issued for delivery, amended, renewed or continued in this state on or
230 after January 1, 2018, shall provide coverage for the medically necessary
231 expenses for the diagnosis and treatment of infertility, including, but not
232 limited to, ovulation induction, intrauterine insemination, in-vitro
233 fertilization, uterine embryo lavage, embryo transfer, gamete intra-
234 fallopian transfer, zygote intra-fallopian transfer and low tubal ovum

235 transfer. For purposes of this section, "infertility" means [the condition
236 of an individual who is unable to conceive or produce conception or
237 sustain a successful pregnancy during a one-year period or such
238 treatment is medically necessary] (1) the inability to establish or carry a
239 pregnancy based on an individual's medical, sexual and reproductive
240 history, age, physical findings, diagnostic testing or any combination of
241 such factors, including, but not limited to, infertility arising from
242 disabilities or from medical treatments or conditions associated with a
243 disability, (2) the need for medical intervention, including, but not
244 limited to, the use of donor gametes, donor embryos or a gestational
245 surrogate, to establish a pregnancy either as an individual or with a
246 partner, (3) an individual's inability to establish a pregnancy or carry a
247 pregnancy to live birth after twelve months of unprotected sexual
248 intercourse when the individual and the individual's partner have the
249 necessary gametes to establish a pregnancy, provided a pregnancy loss
250 shall not restart the twelve-month period, and (4) an individual's
251 inability to establish a pregnancy or to carry a pregnancy to live birth
252 after six months of unprotected sexual intercourse due to the
253 individual's age when the individual and the individual's partner have
254 the necessary gametes to establish a pregnancy, provided a pregnancy
255 loss shall not restart the six-month period.

256 Sec. 11. Subdivision (4) of subsection (b) of section 38a-536 of the
257 general statutes is repealed and the following is substituted in lieu
258 thereof (*Effective January 1, 2027*):

259 (4) Limit coverage for in-vitro fertilization, gamete intra-fallopian
260 transfer, zygote intra-fallopian transfer and low tubal ovum transfer to
261 those individuals who [have been unable to conceive or produce
262 conception or sustain a successful] meet the definition of infertility and
263 have been unable to establish a pregnancy or carry a pregnancy through
264 less expensive and medically viable infertility treatment or procedures
265 covered under such policy. Nothing in this subdivision shall be
266 construed to deny the coverage required by this section to any
267 individual who foregoes a particular infertility treatment or procedure
268 if the individual's physician determines that such treatment or

269 procedure is likely to be unsuccessful; and

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2027</i>	38a-1
Sec. 2	<i>January 1, 2027</i>	New section
Sec. 3	<i>January 1, 2027</i>	New section
Sec. 4	<i>January 1, 2027</i>	New section
Sec. 5	<i>January 1, 2027</i>	New section
Sec. 6	<i>January 1, 2027</i>	38a-492t(a)
Sec. 7	<i>January 1, 2027</i>	38a-518t(a)
Sec. 8	<i>January 1, 2027</i>	38a-509(a)
Sec. 9	<i>January 1, 2027</i>	38a-509(b)(4)
Sec. 10	<i>January 1, 2027</i>	38a-536(a)
Sec. 11	<i>January 1, 2027</i>	38a-536(b)(4)

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 27 \$	FY 28 \$
Connecticut Health Insurance Exchange	GF - Potential Cost	39,000	78,000
Social Services, Dept.	GF - Potential Cost	19,000	38,000

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 27 \$	FY 28 \$
Various Municipalities	STATE MANDATE ¹ - Potential Cost	See Below	See Below

Explanation

The bill mandates coverage for: (1) Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) treatments, (2) scalp cooling systems associated with chemotherapy, (3) prosthetic devices used for athletic purposes, and (4) infertility treatment, which results in the potential costs described below.

Exchange and Covered Connecticut

Sections 2 through 5 result in a potential cost to the state of \$58,000

¹ State mandate is defined in Sec. 2-32b(2) of the Connecticut General Statutes, "state mandate" means any state initiated constitutional, statutory or executive action that requires a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

for the partial year coverage in FY 27 and \$116,000 annually thereafter to defray additional premium costs for enrollees purchasing health insurance on the state's exchange. This cost is potential as it is incurred to the extent the new coverage requirements for PANS/PANDAS treatment and scalp cooling systems are determined to increase premiums and constitute new state benefit mandates under the federal Affordable Care Act (ACA).

Under the ACA, states are allowed to mandate benefits beyond the essential health benefits but must pay for that excess coverage. Federal regulations require the state to defray the cost of additional benefits related to specific care, treatment or services mandated by state action after December 31, 2011 (except to comply with federal requirements) for all plans sold on the exchange.²

There are currently 157,246 enrollees in qualified health plans on the exchange, including 51,629 in Covered Connecticut. The Department of Social Services would incur approximately 33% of defrayal costs on behalf of Covered Connecticut enrollees, to the extent the bill raises premiums for those enrollees. It is not clear how or when the ACA defrayal rules will be enforced for the state's exchange.

Insurance coverage for PANS/PANDAS treatments and scalp cooling is estimated to increase premiums by up to \$0.03 per member per month (PMPM) each. The actual increase to premiums will be calculated by insurers offering exchange plans and will depend on utilization rates.³ At \$0.03 PMPM, the total state defrayal cost for the partial year in FY 27 would be \$31,000 and \$27,000, and \$62,000 and \$54,000 annually thereafter for the coverage of PANS/PANDAS and scalp cooling, respectively.

Coverage for prosthetics and infertility treatments result in no impact

² 45 CFR 155.170

³ Utilization rate of 0.009% and 0.006% was used for PANS/PANDAS and scalp cooling, respectively. Figures are based on claims incurred during calendar year 2025 for the state employee and partnership health plans.

to the state since both are currently covered.

Municipalities

Municipalities with fully insured health plans will face costs to the extent their plans do not currently offer coverage for the provisions outlined above. Due to federal law, the coverage requirements will not apply to self-insured municipalities, as they are exempt under Employee Retirement Income Security Act (ERISA).

State Health Plans

There is no fiscal impact to the state employee health plan or the state partnership plan, as both currently cover all treatment requirements outlined in the bill.⁴

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to (1) inflation, (2) enrollment, and (3) utilization of services.

⁴ In calendar year 2025, the state plan covered 220 claims for PANS/PANDAS treatment, totaling \$85,000. The out-of-pocket cost for claimants was \$1,600. The bill does not comment on removing cost sharing related to this treatment. Fourteen claims were processed during the same period related to scalp cooling systems, averaging \$5,400 per claimant. Prosthetics are currently covered under the plan, and the bill makes a clarifying change. The bill additionally codifies the removal of certain limitations on medically necessary infertility diagnosis and treatment coverage, which was previously issued as guidance by the Department of Insurance.

OLR Bill Analysis**sHB 5374****AN ACT CONCERNING HEALTH COVERAGE MANDATES FOR CERTAIN HEALTH CONDITIONS.****SUMMARY**

This bill addresses benefit mandates under certain individual and group health insurance policies (see below).

Specifically, effective January 1, 2027, the bill generally requires the applicable individual and group health insurance policies to provide coverage for the following:

1. Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) treatment, (see BACKGROUND) (§§ 2 & 3);
2. prosthetic devices designed exclusively for athletic purposes (§§ 6 & 7);
3. scalp cooling systems used in connection with chemotherapy, at least equivalent to the coverage Medicare provides for them (§§ 4 & 5); and
4. infertility diagnosis and treatment under an expanded definition of “infertility” that, among other things, establishes various ways in which infertility can be determined (§§ 8-11).

It also applies the definitions of terms with general applicability in the insurance statutes to the new provisions mandating coverage for PANS and PANDAS and scalp cooling systems (§ 1).

The bill’s benefit mandates apply to each insurer, hospital or medical

service corporation, Health Maintenance Organizations HMO, or fraternal benefit society that delivers, issues, renews, amends, or continues in Connecticut individual or group health insurance policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; (4) hospital or medical services, including those provided under an HMO plan; or (5) specified disease coverage. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans. The scalp cooling system benefit mandate also applies to individual and group health insurance policies for specified disease coverage.

EFFECTIVE DATE: January 1, 2027

§§ 2 & 3 — PANS AND PANDAS COVERAGE

Required Coverage

The bill requires certain individual and group health insurance policies (see SUMMARY above) issued for delivery, renewed, amended, or continued in Connecticut on or after January 1, 2027, to provide coverage for the treatment of PANS and PANDAS, including the use of intravenous immunoglobulin therapy.

§§ 4 & 5 — SCALP COOLING SYSTEM

Required Coverage

The bill requires certain individual and group health insurance policies (see SUMMARY above) delivered, issued for delivery, renewed, amended, or continued in Connecticut on or after January 1, 2027, that provide coverage for chemotherapy, to cover scalp cooling systems used in connection with chemotherapy. They must cover it at least equivalent to the coverage provided for it under Medicare. Under the bill, a “scalp cooling system” is any device designed and intended for repeated medical use to cool the human scalp to prevent or reduce hair loss due to chemotherapy.

Out-of-Pocket Expenses

The bill generally prohibits any of the policies from imposing out-of-

pocket expenses (coinsurance, copayment, deductible, or other out-of-pocket expense) for any scalp cooling system that is more restrictive than what is imposed on substantially all other benefits under the policy.

The bill makes an exception for high deductible health plans designed to be compatible with federally qualified health savings accounts.

Prior Authorization

Under the bill, these individual and group health insurance policies may require prior authorization for scalp cooling systems, but only in the same way and to the same extent as required for other covered benefits under the policy.

§§ 6 & 7 — PROSTHETIC DEVICES

The law requires certain individual and group health insurance policies (see SUMMARY above) to cover prosthetic devices, and medically necessary repairs and replacements to them, subject to specified conditions.

Under existing law, a “prosthetic device” is an artificial device to replace all or part of an arm or leg, including one with a microprocessor if the patient’s health care provider determines it is medically necessary. Current law expressly excludes a device that is designed exclusively for athletic purposes. The bill removes this exclusion and in so doing expands the benefit mandate to include coverage for prosthetic devices designed exclusively for athletic purposes. Under existing law, unchanged by the bill, prosthetic devices must not be considered durable medical equipment under the policy.

Required Coverage

Under existing law, insurance coverage for a prosthetic device must be at least equivalent to the coverage Medicare provides for these devices. The law allows a policy to limit coverage to a device that the patient’s health care provider determines is most appropriate to meet his or her medical needs. It also requires policies to cover repairs or

replacements of prosthetic devices that the patient's health care provider determines are medically necessary, but not those needed because of misuse or loss. The bill extends these coverage requirements to the mandated coverage under the bill for prosthetic devices designed exclusively for athletic purposes.

Out-of-Pocket Expenses

Existing law generally prohibits a policy from imposing out-of-pocket expenses (coinsurance, copayment, deductible, or other out-of-pocket expense) for a prosthetic device that is more restrictive than that imposed on most other policy benefits. Under the bill, this prohibition also applies to prosthetic devices designed exclusively for athletic purposes.

Under existing law and the bill, the prohibition does not apply to high deductible plans designed to be compatible with federally qualified health savings accounts.

Prior Authorization

Under existing law, a policy may require prior authorization for prosthetic devices, but only in the same way and to the same extent it requires it for other policy benefits. Under the bill, this also applies to prosthetic devices designed exclusively for athletic purposes.

§§ 8 –11 — INFERTILITY DIAGNOSIS AND TREATMENT

Required Coverage

By law, certain individual and group health insurance policies (see SUMMARY above) must cover the medically necessary costs of diagnosing and treating infertility. Under current law, "infertility" means being unable to conceive or produce conception or sustain a successful pregnancy during a one-year period or the treatment is medically necessary. The bill expands this definition by, among other things, establishing various conditions upon which infertility diagnosis and treatment can be based, including a shorter time period (six months) under specified circumstances, as described below.

Expanded Definition

By expanding the definition of “infertility,” the bill expands the benefit mandate to include the medically necessary cost of diagnosing and treating the following:

1. the inability to establish or carry a pregnancy based on a person’s medical, sexual and reproductive history, age, physical findings, diagnostic testing, or any combination of these factors, including infertility arising from disabilities or from medical treatments or conditions associated with a disability;
2. the need for medical intervention, including the use of donor gametes, donor embryos, or a gestational surrogate, to establish a pregnancy either as an individual or with a partner;
3. a person’s inability to establish a pregnancy or carry a pregnancy to live birth after 12 months of unprotected sexual intercourse when the individual and the individual's partner have the necessary gametes to establish a pregnancy, but a pregnancy loss must not restart the 12-month period; and
4. a person’s inability to establish a pregnancy or carry a pregnancy to live birth after six months of unprotected sexual intercourse due to their age when the person and their partner have the necessary gametes to establish a pregnancy, but a pregnancy loss must not restart the six-month period.

Existing law, unchanged by the bill, allows religious employers and individuals to exclude infertility coverage from their policies if it is contrary to their religious tenets.

Coverage Limitations

The bill makes a conforming change to apply the new definition of infertility to existing coverage limitations.

BACKGROUND

PANS and PANDAS

According to the National Institute of Mental Health, Pediatric

Acute-onset Neuropsychiatric Syndrome (PANS) and Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS) are conditions that are characterized by a sudden and severe onset of obsessive-compulsive disorder or restrictive eating disorder in children before puberty. PANS and PANDAS are also often associated with noticeable changes in mood, behavior, and sensory and motor function in children.

PANS may be triggered by various infections, immune system issues, or environmental factors. PANDAS is a subtype of PANS and is specifically associated with an infection from streptococcal (strep) bacteria, such as strep throat or scarlet fever.

Related Federal Law

Under the federal Patient Protection and Affordable Care Act (P.L. 111-148, § 1311(d)(3)), a state may require health plans sold through the state’s health insurance exchange to offer benefits beyond those included in the required essential health benefits, provided the state defrays the cost of those additional benefits. The requirement applies to state benefit mandates enacted after December 31, 2011. The state must pay the insurance carrier or enrollee to defray the cost of any new benefits it mandates after that date.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 12 Nay 1 (03/12/2026)