PA 26-33—sHB 5374
Insurance and Real Estate Committee
Appropriations Committee

AN ACT CONCERNING HEALTH COVERAGE MANDATES FOR CERTAIN HEALTH CONDITIONS

SUMMARY: This act addresses benefit mandates under certain individual and group health insurance policies.

Specifically, starting January 1, 2027, the act generally requires the applicable individual and group health insurance policies to cover 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 with chemotherapy, at least equivalent to their Medicare coverage (§§ 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).

Starting January 1, 2027, the act'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; or (4) hospital or medical services, including those provided under an HMO plan (collectively referred to as "covered policies" below). 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 act requires covered policies to cover the treatment of PANS and PANDAS, including the use of intravenous immunoglobulin therapy.

§§ 4 & 5 — SCALP COOLING SYSTEM

Required Coverage

The act requires covered policies, as well as applicable policies covering specified disease coverage, that provide coverage for chemotherapy to also cover scalp cooling systems used with chemotherapy. The coverage must at least equal Medicare's coverage for it. Under the act, 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 act generally prohibits any of the covered 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. It makes an exception for high deductible health plans designed to be compatible with federally qualified health savings accounts.

Prior Authorization

Under the act, 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 the policy's other covered benefits.

§§ 6 & 7 — PROSTHETIC DEVICES

The act expands the existing prosthetic device benefit mandate by requiring covered policies to also cover prosthetic devices designed exclusively for athletic purposes, and any 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. Under the law, unchanged by the act, prosthetic devices may not be considered durable medical equipment under the policy.

Prior law expressly excluded a device designed exclusively for athletic purposes. The act removes this exclusion, which expands the benefit mandate to include coverage for these devices. By doing so, it applies existing law's provisions to this coverage including (1) generally requiring it to at least equal Medicare's coverage for these devices, (2) generally prohibiting a policy from imposing out-of-pocket expenses that are more restrictive than most other benefits under the policy, and (3) limiting prior authorization requirements to the same manner and extent as required for other policy benefits.

§§ 8–11 — INFERTILITY DIAGNOSIS AND TREATMENT

Required Coverage

By law, covered policies must cover the medically necessary costs of diagnosing and treating infertility. Under prior law, "infertility" was defined as being unable to conceive or produce conception or sustain a successful pregnancy during a one-year period or if the treatment is medically necessary. The act expands this definition by, among other things, establishing various conditions upon which infertility diagnosis and treatment can be based, including a shorter period (six months) under specified circumstances, as described below. It also makes conforming changes.

Expanded Definition

By expanding the definition of "infertility," the act 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 may 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 act, allows religious employers and individuals to exclude infertility coverage from their policies if it is contrary to their religious tenets.

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 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 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, as long as 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.