
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)