



DRAFT

General Assembly

Bill No.

February Session, 2020

LCO No. 3601

Referred to Committee on

Introduced by:

AN ACT CONCERNING DIABETES AND HIGH DEDUCTIBLE HEALTH PLANS.

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

1 Section 1. (NEW) (*Effective from passage*) (a) For the purposes of this
2 section:

3 (1) "Commissioner" means the Commissioner of Social Services;

4 (2) "Covered entity" has the same meaning as provided in Section
5 340B of the Public Health Service Act, 42 USC 256b, as amended from
6 time to time;

7 (3) "Covered outpatient drug" has the same meaning as said term is
8 used in Section 340B of the Public Health Service Act, 42 USC 256b, as
9 amended from time to time;

10 (4) "Department" means the Department of Social Services; and

11 (5) "Federally-qualified health center" has the same meaning as
12 provided in Section 1905(l)(2)(B) of the Social Security Act, 42 USC

DRAFT

Bill No.

13 1396d(l)(2)(B), as amended from time to time.

14 (b) (1) Not later than November 1, 2020, the commissioner shall
15 establish a working group to:

16 (A) Determine whether the commissioner should establish a program
17 to assist individuals in this state who have been diagnosed with diabetes
18 by referring said individuals to federally-qualified health centers and
19 other covered entities for treatment regardless of whether said
20 individuals have health coverage; and

21 (B) If the working group determines that the commissioner should
22 establish the program described in subparagraph (A) of this
23 subdivision, develop the criteria that the department shall apply in
24 recommending a federally-qualified health center or other covered
25 entity to an individual described in said subparagraph based on the
26 individual's diabetic condition, any medically necessary care for said
27 condition, the individual's residence address and any other factors that
28 the working group deems relevant to carry out the purposes of the
29 program.

30 (2) The working group shall consist of the following members:

31 (A) Two members appointed by the chief executive officer of
32 Community Health Center, Incorporated, or the legal successor to said
33 entity;

34 (B) Two members appointed by the chief executive officer of
35 Community Health Center Association of Connecticut, Incorporated, or
36 the legal successor to said entity;

37 (C) One member appointed by the Senate chairman of the joint
38 standing committee of the General Assembly having cognizance of
39 matters relating to insurance, who shall be an advocate for insulin
40 coverage or public health;

DRAFT

Bill No.

41 (D) One member appointed by the House chairman of the joint
42 standing committee of the General Assembly having cognizance of
43 matters relating to insurance, who shall be an advocate for the interests
44 of hospitals;

45 (E) One member appointed by the Senate ranking member of the joint
46 standing committee of the General Assembly having cognizance of
47 matters relating to insurance, who shall have experience with health
48 care inequality;

49 (F) One member appointed by the House ranking member of the joint
50 standing committee of the General Assembly having cognizance of
51 matters relating to insurance, who shall be an advocate for insulin
52 coverage or public health;

53 (G) The commissioner, or the commissioner's designee; and

54 (H) The Secretary of the Office of Policy and Management, or the
55 secretary's designee.

56 (3) All initial appointments to the working group shall be made not
57 later than November 1, 2020. Any vacancy shall be filled by the
58 appointing authority.

59 (4) The commissioner shall select a chairperson of the working group
60 from among the members of the working group. Such chairperson shall
61 schedule the first meeting of the working group, which shall be held not
62 later than January 10, 2021.

63 (5) A majority of the members of the working group shall constitute
64 a quorum for the transaction of any business. Any action taken by the
65 working group shall be by majority vote of the members present.

66 (6) Not later than May 1, 2021, the working group shall, in accordance
67 with the provisions of section 11-4a of the general statutes, submit its
68 recommendation under subparagraph (A) of subdivision (1) of this

DRAFT

Bill No.

69 subsection and criteria, if any, developed under subparagraph (B) of
70 subdivision (1) of this subsection to the commissioner and the joint
71 standing committee of the General Assembly having cognizance of
72 matters relating to insurance. The working group shall terminate on the
73 date that the working group submits its recommendation and criteria, if
74 any, pursuant to this subdivision or May 1, 2021, whichever is later.

75 (7) The commissioner may reestablish the working group after May
76 1, 2021, to develop new criteria described in subparagraph (B) of
77 subdivision (1) of this subsection in accordance with the requirements
78 of subdivisions (1) to (6), inclusive, of this subsection, except as
79 otherwise provided in this subdivision. The commissioner shall send
80 notice to each appointing authority disclosing that the commissioner
81 has reestablished the working group and the date on which the
82 commissioner reestablished the working group. The appointing
83 authorities shall appoint all members of the reestablished working
84 group not later than sixty days after the date on which the commissioner
85 reestablished the working group. The commissioner shall schedule the
86 first meeting of the reestablished working group for a date that is not
87 later than ninety days after the date on which the commissioner
88 reestablished the working group. The reestablished working group shall
89 submit its new criteria to the commissioner and the joint standing
90 committee of the General Assembly having cognizance of matters
91 relating to insurance, in accordance with the provisions of section 11-4a
92 of the general statutes, not later than two hundred forty days after the
93 commissioner reestablished the working group. The reestablished
94 working group shall terminate on the date that it submits said criteria
95 or on that date that is two hundred forty days after the commissioner
96 reestablished the working group, whichever is later.

97 (c) (1) Not later than January 1, 2022, the commissioner shall establish
98 the program described in subparagraph (A) of subdivision (1) of
99 subsection (b) of this section, and the department shall apply the criteria
100 developed pursuant to subparagraph (B) of subdivision (1) of

101 subsection (b) of this section, unless:

102 (A) The working group recommends, pursuant to subparagraph (A)
103 of subdivision (1) of subsection (b) of this section, that the commissioner
104 should not establish said program; or

105 (B) Not later than October 1, 2021, the commissioner submits, in
106 accordance with section 11-4a of the general statutes, to the joint
107 standing committee of the General Assembly having cognizance of
108 matters relating to insurance:

109 (i) The commissioner's determination that the goals of said program
110 would, in the commissioner's judgment, be more successfully
111 accomplished by applying for a Medicaid research and demonstration
112 waiver under Section 1115 of the Social Security Act, as amended from
113 time to time; or

114 (ii) A memorandum prepared by the general counsel of the
115 department detailing the barriers federal law poses to the establishment
116 and successful implementation of said program.

117 (2) If the commissioner informs the joint standing committee of the
118 General Assembly having cognizance of matters relating to insurance
119 that the commissioner has determined that the goals of the program
120 described in subparagraph (A) of subdivision (1) of subsection (b) of this
121 section would, in the commissioner's judgment, be more successfully
122 accomplished by applying for a Medicaid research and demonstration
123 waiver under Section 1115 of the Social Security Act, as amended from
124 time to time, the commissioner shall apply for such a waiver to establish
125 said program and, if the Centers for Medicare and Medicaid Services
126 approves the commissioner's waiver application, establish said program
127 in accordance with the terms of such waiver and all federal and state
128 laws governing said program.

129 (d) If the commissioner establishes the program pursuant to

DRAFT

Bill No.

130 subsection (c) of this section, the commissioner shall, as part of said
131 program, establish and maintain an Internet web site to collect
132 information from, and provide information to, each individual in this
133 state who has been diagnosed with diabetes by referring the individual
134 to a federally-qualified health center or other covered entity for
135 treatment regardless of whether such individual has health coverage.
136 The Internet web site shall, at a minimum:

137 (1) Enable the individual to disclose to the department the
138 individual's name, residence address, age, contact information,
139 including, but not limited to, electronic mail address or telephone
140 number, income and race, whether the individual has been diagnosed
141 with diabetes and the name of each outpatient prescription drug that
142 has been prescribed to the individual for the treatment of diabetes; and

143 (2) Enable the department to:

144 (A) Determine whether each outpatient prescription drug disclosed
145 to the department pursuant to subdivision (1) of this subsection is a
146 covered outpatient drug that is available at a reduced cost to the
147 individual through a federally-qualified health center that is a covered
148 entity or any other covered entity;

149 (B) Disclose to the individual:

150 (i) The name, business address and telephone number of any
151 federally-qualified health center that is a covered entity or any other
152 covered entity that the department recommends to the individual
153 according to the criteria established pursuant to subsection (b) of this
154 section; and

155 (ii) General information regarding health care provided by the
156 recommended federally-qualified health center or other covered entity
157 described in subparagraph (B)(i) of this subdivision, including, but not
158 limited to, any information that would assist the individual to obtain

159 primary care through such federally-qualified health center or other
160 covered entity; and

161 (C) Disclose to the recommended federally-qualified health center or
162 other covered entity described in subparagraph (B)(i) of this subdivision
163 the individual's name, contact information and a statement disclosing
164 that the department has recommended the federally-qualified health
165 center or other covered entity to the individual.

166 (e) Each federally-qualified health center or other covered entity that
167 receives an individual's name, contact information and a statement
168 disclosing that the department has recommended the federally-
169 qualified health center or other covered entity to an individual pursuant
170 to subparagraph (C) of subdivision (2) of subsection (d) of this section
171 shall make a good faith effort to schedule an appointment for the
172 individual on a date that is not later than thirty days after the date on
173 which the department disclosed to the recommended federally-
174 qualified health center or other covered entity the information described
175 in said subparagraph (C) of subdivision (2) of subsection (d) of this
176 section.

177 (f) The commissioner may adopt regulations, in accordance with the
178 provisions of chapter 54 of the general statutes, to carry out the purposes
179 of this section.

180 Sec. 2. Section 20-571 of the general statutes is repealed and the
181 following is substituted in lieu thereof (*Effective January 1, 2021*):

182 **Sec. 20-571. (Formerly Sec. 20-184a). Definitions.** As used in sections
183 20-570 to 20-630, inclusive, unless the context otherwise requires:

184 (1) "Administer" means the direct application of a drug or device to
185 the body of a patient or research subject by injection, inhalation,
186 ingestion or any other means;

DRAFT

Bill No.

187 (2) "Care-giving institution" means an institution that provides
188 medical services and is licensed, operated, certified or approved by the
189 Commissioner of Public Health, the Commissioner of Developmental
190 Services or the Commissioner of Mental Health and Addiction Services;

191 (3) "Commission" means the Commission of Pharmacy appointed
192 under the provisions of section 20-572;

193 (4) "Commissioner" means the Commissioner of Consumer
194 Protection;

195 (5) "Compound" means to combine, mix or put together two or more
196 ingredients pursuant to a prescription and includes the preparation of
197 drugs or devices in anticipation of prescriptions based on routine,
198 regularly-observed prescribing patterns;

199 (6) "Correctional or juvenile training institution" means a facility for
200 the detention or incarceration of persons convicted or accused of crimes
201 or offenses or for training of delinquent juveniles, including those state
202 facilities under the jurisdiction of the Commissioner of Correction,
203 training schools for delinquent juveniles and any other facilities
204 operated by the state or municipalities for such detention, incarceration
205 or training;

206 (7) "Device" means instruments, apparatuses and contrivances,
207 including their components, parts and accessories, intended (A) for use
208 in the diagnosis, cure, mitigation, treatment or prevention of disease in
209 humans or other animals, or (B) to affect the structure or any function of
210 the body of humans or other animals, but does not mean contact lenses;

211 (8) "Department" means the Department of Consumer Protection;

212 (9) "Dispense" means those acts of processing a drug or device for
213 delivery or for administration for a patient pursuant to a prescription
214 consisting of: (A) Comparing the directions on the label with the

DRAFT

Bill No.

215 directions on the prescription to determine accuracy; (B) the selection of
216 the drug or device from stock to fill the prescription; (C) the counting,
217 measuring, compounding or preparation of the drug or device; (D) the
218 placing of the drug or device in the proper container; (E) the affixing of
219 the label to the container; and (F) the addition to a written prescription
220 of any required notations. "Dispense" does not include the acts of
221 delivering a drug or device to a patient or of administering the drug or
222 device to the patient;

223 (10) "Dispensing outpatient facility" means a facility operated by a
224 corporation or municipality which provides medical services to patients
225 on an outpatient basis and which maintains stocks of drugs for
226 dispensing of drugs on a regular basis to patients for use off the
227 premises;

228 (11) "Drug" means (A) an article recognized in the official United
229 States Pharmacopoeia, official Homeopathic Pharmacopoeia of the
230 United States or official National Formulary, or any supplement to any
231 of them, (B) an article intended for use in the diagnosis, cure, mitigation,
232 treatment or prevention of disease in humans or other animals, (C) an
233 article, other than food, intended to affect the structure or any function
234 of the body of humans or any other animal, and (D) an article intended
235 for use as a component of any article specified in this subdivision, but
236 does not include a device;

237 (12) "Institutional pharmacy" means that area within a care-giving
238 institution or within a correctional or juvenile training institution,
239 commonly known as the pharmacy, that is under the direct charge of a
240 pharmacist and in which drugs are stored and dispensed;

241 (13) "Legend device" means a device that is required by applicable
242 federal or state law to be dispensed pursuant only to a prescription or is
243 restricted to use by prescribing practitioners only or that, under federal
244 law, is required to bear either of the following legends: (A) "RX ONLY"

DRAFT

Bill No.

245 IN ACCORDANCE WITH GUIDELINES ESTABLISHED IN THE
246 FEDERAL FOOD, DRUG AND COSMETIC ACT; or (B) "CAUTION:
247 FEDERAL LAW RESTRICTS THIS DEVICE FOR USE BY OR ON THE
248 ORDER OF A LICENSED VETERINARIAN.";

249 (14) "Legend drug" means a drug that is required by any applicable
250 federal or state law to be dispensed pursuant only to a prescription or is
251 restricted to use by prescribing practitioners only, or means a drug that,
252 under federal law, is required to bear either of the following legends:
253 (A) "RX ONLY" IN ACCORDANCE WITH GUIDELINES
254 ESTABLISHED IN THE FEDERAL FOOD, DRUG AND COSMETIC
255 ACT; or (B) "CAUTION: FEDERAL LAW RESTRICTS THIS DRUG FOR
256 USE BY OR ON THE ORDER OF A LICENSED VETERINARIAN.";

257 (15) "Medical device and oxygen provider" means a person who
258 distributes devices or oxygen pursuant to a medical order or
259 prescription, except if such person already maintains an active
260 pharmacy license;

261 (16) "Nonlegend device" means a device that is not a legend device;

262 ~~[(16)]~~ (17) "Nonlegend drug" means a drug that is not a legend drug;

263 ~~[(17)]~~ (18) "Person" means an individual, corporation, business trust,
264 estate trust, partnership, association, joint venture or any other legal or
265 commercial entity;

266 ~~[(18)]~~ (19) "Pharmacist" means an individual who is licensed to
267 practice pharmacy under the provisions of section 20-590, 20-591, 20-592
268 or 20-593, and who is thereby recognized as a health care provider by
269 the state of Connecticut;

270 ~~[(19)]~~ (20) "Pharmacy" means a place of business where drugs and
271 devices may be sold at retail and for which a pharmacy license has been
272 issued to an applicant under the provisions of section 20-594;

DRAFT

Bill No.

273 [(20)] (21) "Pharmacy intern" means an individual registered under
274 the provisions of section 20-598;

275 [(21)] (22) "Pharmacy technician" means an individual who is
276 registered with the department and qualified in accordance with section
277 20-598a;

278 [(22)] (23) "Practice of pharmacy" or "to practice pharmacy" means the
279 sum total of knowledge, understanding, judgments, procedures,
280 securities, controls and ethics used by a pharmacist to assure optimal
281 safety and accuracy in the distributing, dispensing and use of drugs and
282 devices;

283 [(23)] (24) "Prescribing practitioner" means an individual licensed by
284 the state of Connecticut, any other state of the United States, the District
285 of Columbia, the Commonwealth of Puerto Rico or any territory or
286 insular possession subject to the jurisdiction of the United States who is
287 authorized to issue a prescription within the scope of the individual's
288 practice;

289 [(24)] (25) "Prescription" means a lawful order of a prescribing
290 practitioner transmitted either orally, in writing or by electronic means
291 for a drug or device for a specific patient;

292 [(25)] (26) "Sale" includes barter, exchange or gift or offer and each
293 such transaction made by a person whether as principal proprietor,
294 agent, servant or employee;

295 [(26)] (27) "Substitute" means to dispense without the prescribing
296 practitioner's express authorization a different drug product than the
297 drug product prescribed;

298 [(27)] (28) "Third-party logistics provider" means a person who
299 distributes drugs, devices or cosmetics while taking possession of the
300 drugs, devices or cosmetics but who does not take title of the drugs,

301 devices or cosmetics;

302 [(28)] (29) "Virtual manufacturer" means a person who engages in the
303 manufacture of drugs, devices or cosmetics for which such person: (A)
304 Owns the new drug application or abbreviated new drug application
305 number, if a prescription drug; (B) owns the unique device identification
306 number, as available, for a prescription device; (C) contracts with a
307 contract manufacturing organization for the physical manufacture of
308 the drugs, devices or cosmetics; (D) is not involved in the physical
309 manufacture of the drugs, devices or cosmetics; and (E) at no time takes
310 physical possession of or stores the drugs, devices or cosmetics; and

311 [(29)] (30) "Virtual wholesale distributor" means a person who
312 facilitates or brokers the transfer of drugs, devices or cosmetics without
313 taking physical possession of the drugs, devices or cosmetics.

314 Sec. 3. Section 20-616 of the general statutes is repealed and the
315 following is substituted in lieu thereof (*Effective January 1, 2021*):

316 (a) As used in this section:

317 (1) "Diabetes equipment and supplies" means devices, including, but
318 not limited to, blood glucose test strips, glucometers, lancets, lancing
319 devices and insulin syringes, that are (A) legend devices or nonlegend
320 devices, (B) used to treat diabetes, and (C) necessary to administer an
321 insulin drug; and

322 (2) "Insulin drug" means a drug, including, but not limited to, an
323 insulin pen, that contains insulin and is (A) a legend drug or nonlegend
324 drug, (B) prescribed for self-administration on an outpatient basis, and
325 (C) approved by the federal Food and Drug Administration to treat
326 diabetes.

327 [(a)] (b) Except as provided in subsection [(b)] (c) or (d) of this section,
328 a prescription may be refilled only upon the written, oral or

329 electronically-transmitted order of a prescribing practitioner.

330 [(b)] (c) A pharmacist may exercise his professional judgment in
331 refilling a prescription that is not for a controlled drug, as defined in
332 section 21a-240, without the authorization of the prescribing
333 practitioner, provided (1) the pharmacist is unable to contact such
334 practitioner after reasonable effort, (2) failure to refill the prescription
335 might result in an interruption of a therapeutic regimen or create patient
336 suffering, and (3) the pharmacist informs the patient or representative
337 of the patient at the time of dispensing that the refill is being provided
338 without such authorization and informs the practitioner at the earliest
339 reasonable time that authorization of the practitioner is required for
340 future refills. Prescriptions may be refilled once pursuant to this
341 subsection for a quantity of drug not to exceed a seventy-two hour
342 supply.

343 (d) (1) (A) Notwithstanding subsection (c) of this section, a
344 pharmacist may immediately prescribe and dispense to a patient not
345 more than a thirty-day supply of an insulin drug, and any diabetes
346 equipment and supplies that are necessary to administer such supply of
347 the insulin drug, if:

348 (i) The patient informs the pharmacist that the patient has less than a
349 seven-day supply of such insulin drug;

350 (ii) The pharmacist determines, in the pharmacist's professional
351 judgment, that the patient will likely suffer significant physical harm
352 within seven days if the patient does not obtain an additional supply of
353 such insulin drug, and any diabetes equipment and supplies that are
354 necessary to administer such insulin drug, before the expiration of said
355 seven days; and

356 (iii) The pharmacist reviews the electronic prescription drug
357 monitoring program established pursuant to section 21a-254 and
358 determines that no pharmacist prescribed and dispensed a supply of

DRAFT

Bill No.

359 such insulin drug, and any diabetes equipment and supplies that are
360 necessary to administer such insulin drug, to the patient pursuant to this
361 subsection during the twelve-month period immediately preceding,
362 unless:

363 (I) The pharmacist determines, by contacting the pharmacy that filled
364 the most recent prescription for such insulin drug, by examining
365 another prescription database or reviewing the most recent prescription
366 for such insulin drug or a prescription label containing the most recent
367 prescription information for such insulin drug, that no pharmacist
368 dispensed a supply of such insulin drug to the patient pursuant to this
369 subsection during said twelve-month period; or

370 (II) The electronic prescription drug monitoring program established
371 pursuant to section 21a-254 is unavailable.

372 (B) A pharmacist shall immediately prescribe and dispense to a
373 patient not more than a thirty-day supply of an insulin drug, and any
374 diabetes equipment and supplies that are necessary to administer such
375 supply of the insulin drug, if the criteria established in subparagraphs
376 (A)(i) to (A)(iii), inclusive, of this subdivision have been satisfied and
377 the patient pays, or has health insurance coverage, for such insulin drug
378 and diabetes equipment and supplies.

379 (2) No pharmacist that prescribes and dispenses an insulin drug, and
380 the diabetes equipment and supplies necessary to administer the insulin
381 drug, pursuant to subdivision (1) of this subsection shall require the
382 patient to tender payment to the pharmacist for such insulin drug and
383 diabetes equipment and supplies in an amount that exceeds:

384 (A) The amount of the coinsurance, copayment, deductible or other
385 out-of-pocket expense imposed by the patient's health insurance
386 coverage for such insulin drug and diabetes equipment and supplies; or

387 (B) The full market cost for such prescription drug and diabetes

DRAFT

Bill No.

388 equipment and supplies if the patient does not have health insurance
389 coverage for such insulin drug or diabetes equipment and supplies.

390 (3) Nothing in subdivision (1) or (2) of this subsection shall be
391 construed to prohibit a pharmacist from requiring a patient to submit to
392 the pharmacist, prior to prescribing or dispensing an insulin drug or
393 diabetes equipment and supplies pursuant to said subdivisions, proof
394 of health insurance coverage for the patient, personal identification for
395 the patient, contact information for a health care provider providing
396 treatment to the patient, information concerning previous prescriptions
397 issued to the patient for the insulin drug, a sworn statement by the
398 patient stating that the patient is unable to timely obtain the insulin drug
399 or diabetes equipment and supplies that the patient is seeking pursuant
400 to this subsection without suffering significant physical harm, and any
401 amount required by the pharmacist under subdivision (2) of this
402 subsection.

403 (4) Each pharmacist shall refer a patient who requests a supply of an
404 insulin drug pursuant to this subsection to a federally-qualified health
405 center if (A) the pharmacist determines that the patient does not have
406 health insurance coverage for such supply of such insulin drug, or (B)
407 the patient informs the pharmacist that the patient is concerned that the
408 net cost to the patient for such supply of such covered insulin drug is
409 unaffordable.

410 [(c)] (e) Any prescription that is not for a controlled drug, as defined
411 in section 21a-240, may be transferred orally or electronically between
412 pharmacies, provided:

413 (1) The prescribing practitioner has authorized the original
414 prescription to be refilled in accordance with subsection [(a)] (b) of this
415 section;

416 (2) The pharmacist transferring the prescription shall cancel the
417 original prescription in such pharmacist's records and shall indicate in

DRAFT

Bill No.

418 such records the name of the pharmacy to which the prescription is
419 transferred and the date of the transfer, provided, such cancellation
420 shall not be required in the case of any transfer between pharmacies
421 which electronically access the same prescription records and utilize the
422 same computer or other electronic prescription transfer system; and

423 (3) The pharmacist receiving the prescription shall indicate in such
424 pharmacist's records, in addition to any other information required by
425 law, (A) the fact that the prescription has been transferred and the
426 names of the transferring pharmacy and pharmacist, (B) the date of
427 issuance and the prescription number of the original prescription, (C)
428 the date the original prescription was first dispensed, (D) the number of
429 refills authorized by the original prescription and the complete refill
430 record for the prescription as of the date of the transfer, and (E) the
431 number of valid refills remaining as of the date of the transfer.

432 Sec. 4. (*Effective from passage*) Not later than October 1, 2020, the
433 Commissioner of Consumer Protection shall send a notice to each
434 pharmacy disclosing the requirements established in subsection (d) of
435 section 20-616 of the general statutes, as amended by section 3 of this
436 act. For the purposes of this section, "pharmacy" has the same meaning
437 as provided in section 20-571 of the general statutes, as amended by
438 section 3 of this act.

439 Sec. 5. Subsection (j) of section 21a-254 of the 2020 supplement to the
440 general statutes is repealed and the following is substituted in lieu
441 thereof (*Effective January 1, 2021*):

442 (j) (1) The commissioner shall, within available appropriations,
443 establish an electronic prescription drug monitoring program to collect,
444 by electronic means, prescription information for schedules II, III, IV
445 and V controlled substances that are dispensed by pharmacies,
446 nonresident pharmacies, as defined in section 20-627, outpatient
447 pharmacies in hospitals or institutions or by any other dispenser. The

DRAFT

Bill No.

448 program shall be designed to provide information regarding the
449 prescription of controlled substances in order to prevent the improper
450 or illegal use of the controlled substances and shall not infringe on the
451 legitimate prescribing of a controlled substance by a prescribing
452 practitioner acting in good faith and in the course of professional
453 practice.

454 (2) The commissioner may identify other products or substances to
455 be included in the electronic prescription drug monitoring program
456 established pursuant to subdivision (1) of this subsection.

457 (3) Prior to July 1, 2016, each pharmacy, nonresident pharmacy, as
458 defined in section 20-627, outpatient pharmacy in a hospital or
459 institution and dispenser shall report to the commissioner, at least
460 weekly, by electronic means or, if a pharmacy or outpatient pharmacy
461 does not maintain records electronically, in a format approved by the
462 commissioner, the following information for all controlled substance
463 prescriptions dispensed by such pharmacy or outpatient pharmacy: (A)
464 Dispenser identification number; (B) the date the prescription for the
465 controlled substance was filled; (C) the prescription number; (D)
466 whether the prescription for the controlled substance is new or a refill;
467 (E) the national drug code number for the drug dispensed; (F) the
468 amount of the controlled substance dispensed and the number of days'
469 supply of the controlled substance; (G) a patient identification number;
470 (H) the patient's first name, last name and street address, including
471 postal code; (I) the date of birth of the patient; (J) the date the
472 prescription for the controlled substance was issued by the prescribing
473 practitioner and the prescribing practitioner's Drug Enforcement
474 Agency's identification number; and (K) the type of payment.

475 (4) (A) Except as provided in this subdivision, on and after July 1,
476 2016, each pharmacy, nonresident pharmacy, as defined in section 20-
477 627, outpatient pharmacy in a hospital or institution, and dispenser shall
478 report to the commissioner by electronic means, in a format approved

479 by the commissioner, the following information for all controlled
480 substance prescriptions dispensed by such pharmacy or outpatient
481 pharmacy immediately upon, but in no event later than the next
482 business day after, dispensing such prescriptions: (i) Dispenser
483 identification number; (ii) the date the prescription for the controlled
484 substance was filled; (iii) the prescription number; (iv) whether the
485 prescription for the controlled substance is new or a refill; (v) the
486 national drug code number for the drug dispensed; (vi) the amount of
487 the controlled substance dispensed and the number of days' supply of
488 the controlled substance; (vii) a patient identification number; (viii) the
489 patient's first name, last name and street address, including postal code;
490 (ix) the date of birth of the patient; (x) the date the prescription for the
491 controlled substance was issued by the prescribing practitioner and the
492 prescribing practitioner's Drug Enforcement Agency's identification
493 number; and (xi) the type of payment.

494 (B) If the electronic prescription drug monitoring program is not
495 operational, such pharmacy or dispenser shall report the information
496 described in this subdivision not later than the next business day after
497 regaining access to such program. For purposes of this subdivision,
498 "business day" means any day during which the pharmacy is open to
499 the public.

500 (C) Each veterinarian, licensed pursuant to chapter 384, who
501 dispenses a controlled substance prescription shall report to the
502 commissioner the information described in subparagraph (A) of this
503 subdivision, at least weekly, by electronic means or, if the veterinarian
504 does not maintain records electronically, in a format approved by the
505 commissioner.

506 (5) The commissioner may contract with a vendor for purposes of
507 electronically collecting such controlled substance prescription
508 information. The commissioner and any such vendor shall maintain the
509 information in accordance with the provisions of chapter 400j.

DRAFT

Bill No.

510 (6) The commissioner and any such vendor shall not disclose
511 controlled substance prescription information reported pursuant to
512 subdivisions (3) and (4) of this subsection, except as authorized
513 pursuant to the provisions of sections 21a-240 to 21a-283, inclusive. Any
514 person who knowingly violates any provision of this subdivision or
515 subdivision (5) of this subsection shall be guilty of a class D felony.

516 (7) The commissioner shall provide, upon request, controlled
517 substance prescription information obtained in accordance with
518 subdivisions (3) and (4) of this subsection to the following: (A) The
519 prescribing practitioner or such practitioner's authorized agent, who is
520 treating or has treated a specific patient, provided the information is
521 obtained for purposes related to the treatment of the patient, including
522 the monitoring of controlled substances obtained by the patient; (B) the
523 prescribing practitioner with whom a patient has made contact for the
524 purpose of seeking medical treatment or such practitioner's authorized
525 agent, provided the request is accompanied by a written consent, signed
526 by the prospective patient, for the release of controlled substance
527 prescription information; or (C) the pharmacist who is dispensing
528 controlled substances for a patient, or such pharmacist's authorized
529 pharmacy technician, provided the information is obtained for purposes
530 related to the scope of the pharmacist's practice and management of the
531 patient's drug therapy, including the monitoring of controlled
532 substances obtained by the patient. The prescribing practitioner, such
533 practitioner's authorized agent, the pharmacist or such pharmacist's
534 authorized pharmacy technician shall submit a written and signed
535 request to the commissioner for controlled substance prescription
536 information. Such prescribing practitioner, pharmacist or pharmacist's
537 authorized pharmacy technician shall not disclose any such request
538 except as authorized pursuant to sections 20-570 to 20-630, inclusive, or
539 sections 21a-240 to 21a-283, inclusive.

540 (8) No person or employer shall prohibit, discourage or impede a
541 prescribing practitioner, pharmacist or pharmacist's authorized

542 pharmacy technician from requesting controlled substance prescription
543 information pursuant to this subsection.

544 (9) Prior to prescribing greater than a seventy-two-hour supply of any
545 controlled substance to any patient, the prescribing practitioner or such
546 practitioner's authorized agent shall review the patient's records in the
547 electronic prescription drug monitoring program established pursuant
548 to this subsection. Whenever a prescribing practitioner prescribes a
549 controlled substance, other than a schedule V nonnarcotic controlled
550 substance, for the continuous or prolonged treatment of any patient,
551 such prescriber, or such prescriber's authorized agent, shall review, not
552 less than once every ninety days, the patient's records in such
553 prescription drug monitoring program. Whenever a prescribing
554 practitioner prescribes a schedule V nonnarcotic controlled substance,
555 for the continuous or prolonged treatment of any patient, such
556 prescribing practitioner, or such prescribing practitioner's authorized
557 agent, shall review, not less than annually, the patient's records in such
558 prescription drug monitoring program. If such electronic prescription
559 drug monitoring program is not operational, such prescribing
560 practitioner may prescribe greater than a seventy-two-hour supply of a
561 controlled substance to a patient during the time of such program's
562 inoperability, provided such prescribing practitioner or such authorized
563 agent reviews the records of such patient in such program not more than
564 twenty-four hours after regaining access to such program.

565 (10) (A) A prescribing practitioner may designate an authorized
566 agent to review the electronic prescription drug monitoring program
567 and patient controlled substance prescription information on behalf of
568 the prescribing practitioner. The prescribing practitioner shall ensure
569 that any authorized agent's access to such program and patient
570 controlled substance prescription information is limited to the purposes
571 described in this section and occurs in a manner that protects the
572 confidentiality of information that is accessed through such program.
573 The prescribing practitioner and any authorized agent shall be subject

574 to the provisions of 45 CFR 164.308, as amended from time to time,
575 concerning administrative safeguards for the protection of electronic
576 protected health information. A prescribing practitioner may be subject
577 to disciplinary action for acts of the authorized agent as provided in
578 section 21a-322.

579 (B) Notwithstanding the provisions of subparagraph (A) of this
580 subdivision, a prescribing practitioner who is employed by or provides
581 professional services to a hospital shall, prior to designating an
582 authorized agent to review the electronic prescription drug monitoring
583 program and patient controlled substance prescription information on
584 behalf of the prescribing practitioner, (i) submit a request to designate
585 one or more authorized agents for such purposes and a written protocol
586 for oversight of the authorized agent or agents to the commissioner, in
587 the form and manner prescribed by the commissioner, and (ii) receive
588 the commissioner's approval to designate such authorized agent or
589 agents and of such written protocol. Such written protocol shall
590 designate either the hospital's medical director, a hospital department
591 head, who is a prescribing practitioner, or another prescribing
592 practitioner as the person responsible for ensuring that the authorized
593 agent's or agents' access to such program and patient controlled
594 substance prescription information is limited to the purposes described
595 in this section and occurs in a manner that protects the confidentiality
596 of information that is accessed through such program. A hospital
597 medical director, a hospital department head, who is a prescribing
598 practitioner, or another prescribing practitioner designated as the
599 person responsible for overseeing an authorized agent's or agents'
600 access to such program and information in the written protocol
601 approved by the commissioner may be subject to disciplinary action for
602 acts of the authorized agent or agents as provided in section 21a-322.
603 The commissioner may inspect hospital records to determine
604 compliance with written protocols approved in accordance with this
605 section.

606 (C) A pharmacist may designate a pharmacy technician to access the
607 electronic prescription drug monitoring program and patient controlled
608 substance prescription information on behalf of the pharmacist only for
609 the purposes of facilitating the pharmacist's review of such patient
610 information. The pharmacist shall ensure that any such pharmacy
611 technician's access to such program and patient controlled substance
612 prescription information is limited to the purposes described in this
613 section and occurs in a manner that protects the confidentiality of
614 information that is accessed through such program. The pharmacist and
615 any authorized pharmacy technician shall be subject to the provisions
616 of 45 CFR 164.308, as amended from time to time, concerning
617 administrative safeguards for the protection of electronic protected
618 health information. A pharmacist may be subject to disciplinary action
619 for acts of the authorized pharmacy technician.

620 (D) Prior to designating a pharmacy technician to access the
621 electronic prescription drug monitoring program and patient controlled
622 substance prescription information on behalf of the pharmacist, the
623 supervising pharmacist shall provide training for the authorized
624 pharmacy technicians. Such training shall designate a pharmacist as the
625 person responsible for ensuring that the authorized pharmacy
626 technician's access to such program and patient controlled substance
627 prescription information is limited to the purposes described in this
628 section and occurs in a manner that protects the confidentiality of
629 information that is accessed through such program. A pharmacist
630 designated as the person responsible for overseeing the pharmacy
631 technician's access to such program may be subject to disciplinary action
632 for acts of the authorized pharmacy technician. The commissioner may
633 inspect records to document pharmacy technician training, that
634 pharmacy technicians have access to the program and that patient
635 controlled substance prescription information has been limited in
636 accordance with the provisions of this section.

637 (11) The commissioner shall adopt regulations, in accordance with

chapter 54, concerning the reporting, evaluation, management and storage of electronic controlled substance prescription information.

(12) The provisions of this section shall not apply to (A) samples of controlled substances dispensed by a physician to a patient, or (B) any controlled substances dispensed to hospital inpatients.

(13) The provisions of this section shall not apply to any institutional pharmacy or pharmacist's drug room operated by a facility, licensed under section 19a-495 and regulations adopted pursuant to said section 19a-495, that dispenses or administers directly to a patient an opioid agonist for treatment of a substance use disorder.

(14) The commissioner may provide controlled substance prescription information obtained in accordance with subdivisions (3) and (4) of this subsection to other state agencies, pursuant to an agreement between the commissioner and the head of such agency, provided the information is obtained for a study of disease prevention and control related to opioid abuse or the study of morbidity and mortality caused by overdoses of controlled substances. The provision of such information shall be in accordance with all applicable state and federal confidentiality requirements.

(15) Nothing in this section shall prohibit a prescribing practitioner or such prescribing practitioner's authorized agent from disclosing controlled substance prescription information submitted pursuant to subdivisions (3) and (4) of this subsection to the Department of Social Services for the purposes of administering any of said department's medical assistance programs.

(16) Each pharmacy, nonresident pharmacy, as defined in section 20-627, outpatient pharmacy in a hospital or institution, and dispenser shall report to the commissioner, at least daily, by electronic means or, if a pharmacy or outpatient pharmacy does not maintain records electronically, in a format approved by the commissioner information

DRAFT

Bill No.

668 for all insulin drugs and diabetes equipment and supplies prescribed
669 and dispensed by such pharmacy or outpatient pharmacy. Such
670 pharmacy or outpatient pharmacy shall report such information to the
671 commissioner in a manner that is consistent with the manner in which
672 such pharmacy or outpatient pharmacy reports information for
673 controlled substance prescriptions pursuant to subdivision (4) of this
674 subsection. For the purposes of this subdivision, "insulin drug" and
675 "diabetes equipment and supplies" have the same meanings as provided
676 in section 20-616.

677 Sec. 6. Subsection (b) of section 21a-65 of the general statutes is
678 repealed and the following is substituted in lieu thereof (*Effective January*
679 *1, 2021*):

680 (b) Except as provided in subsection (a) of this section, no licensed
681 manufacturer, licensed wholesaler or licensed pharmacist shall sell and
682 no person shall buy a hypodermic needle or syringe except upon a
683 prescription of a prescribing practitioner, as defined in subdivision
684 [(22)] (24) of section 20-571, in a quantity greater than ten. Any such
685 prescription shall be retained on file by the seller for a period of not less
686 than three years and shall be accessible to any public officer engaged in
687 the enforcement of this section. Such a prescription shall be valid for one
688 year from the date thereof and purchases and sales may be made
689 thereunder during such period, provided the seller shall confirm the
690 continued need for such sales with such practitioner at least every six
691 months if sales continue to be made thereunder. Hypodermic needles
692 and syringes in a quantity of ten or less without a prescription may be
693 provided or sold at retail only by the following: (1) By a pharmacy
694 licensed in accordance with section 20-594 and in such pharmacy only
695 by a licensed pharmacist or under his direct supervision; (2) by a syringe
696 services program established pursuant to section 19a-124; and (3) by a
697 health care facility or a licensed health care practitioner for use by their
698 own patients.

699 Sec. 7. Subsection (a) of section 21a-70 of the 2020 supplement to the
700 general statutes is repealed and the following is substituted in lieu
701 thereof (*Effective January 1, 2021*):

702 **From 2020 Supplement**

703 **Sec. 21a-70. (Formerly Sec. 19-210). Registration of manufacturers**
704 **and wholesalers of drugs. Sale of drugs limited. (a) Definitions.** As
705 used in this section: (1) "Drugs", "devices" and "cosmetics" have the same
706 meanings as defined in section 21a-92, "wholesaler" or "distributor"
707 means a person, including, but not limited to, a medical device and
708 oxygen provider, a third-party logistics provider, a virtual
709 manufacturer or a virtual wholesale distributor, as such terms are
710 defined in section 20-571, whether within or without the boundaries of
711 the state of Connecticut, who supplies drugs, devices or cosmetics
712 prepared, produced or packaged by manufacturers, to other
713 wholesalers, manufacturers, distributors, hospitals, prescribing
714 practitioners, as defined in subdivision [(22)] (24) of section 20-571,
715 pharmacies, federal, state or municipal agencies, clinics or any other
716 person as permitted under subsection (h) of this section, except that: (A)
717 A retail pharmacy or a pharmacy within a licensed hospital that
718 supplies to another such pharmacy a quantity of a noncontrolled drug
719 or a schedule II, III, IV or V controlled substance normally stocked by
720 such pharmacies to provide for the immediate needs of a patient
721 pursuant to a prescription or medication order of an authorized
722 practitioner, (B) a pharmacy within a licensed hospital that supplies
723 drugs to another hospital or an authorized practitioner for research
724 purposes, (C) a retail pharmacy that supplies a limited quantity of a
725 noncontrolled drug or of a schedule II, III, IV or V controlled substance
726 for emergency stock to a practitioner who is a medical director of a
727 chronic and convalescent nursing home, of a rest home with nursing
728 supervision or of a state correctional institution, and (D) a pharmacy
729 within a licensed hospital that contains another hospital wholly within
730 its physical structure that supplies to such contained hospital a quantity

DRAFT

Bill No.

731 of a noncontrolled drug or a schedule II, III, IV, or V controlled
732 substance normally stocked by such hospitals to provide for the needs
733 of a patient, pursuant to a prescription or medication order of an
734 authorized practitioner, receiving inpatient care on a unit that is
735 operated by the contained hospital shall not be deemed a wholesaler
736 under this section; (2) "manufacturer" means (A) a person, whether
737 within or without the boundaries of the state of Connecticut, who
738 produces, prepares, cultivates, grows, propagates, compounds,
739 converts or processes, directly or indirectly, by extraction from
740 substances of natural origin or by means of chemical synthesis or by a
741 combination of extraction and chemical synthesis, or who packages,
742 repackages, labels or relabels a container under such manufacturer's
743 own or any other trademark or label any drug, device or cosmetic for
744 the purpose of selling such items, or (B) a sterile compounding
745 pharmacy, as defined in section 20-633b, that dispenses sterile
746 pharmaceuticals without a prescription or a patient-specific medical
747 order; (3) "drug", "device" and "cosmetic" have the same meanings as
748 provided in section 21a-92; and (4) "commissioner" means the
749 Commissioner of Consumer Protection or his or her designee.

750 Sec. 8. Subsection (j) of section 21a-249 of the general statutes is
751 repealed and the following is substituted in lieu thereof (*Effective January*
752 *1, 2021*):

753 (j) A pharmacy may sell and dispense controlled substances upon the
754 prescription of a prescribing practitioner, as defined in subdivision
755 [(22)] (24) of section 20-571.

756 Sec. 9. Section 38a-492a of the general statutes is repealed and the
757 following is substituted in lieu thereof (*Effective January 1, 2021*):

758 **Sec. 38a-492a. Mandatory coverage for hypodermic needles and**
759 **syringes.** Each individual health insurance policy providing coverage
760 of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of

DRAFT

Bill No.

761 section 38a-469, delivered, issued for delivery, renewed, amended or
762 continued in this state shall provide coverage for hypodermic needles
763 or syringes prescribed by a prescribing practitioner, as defined in
764 subdivision [(22)] (24) of section 20-571, for the purpose of
765 administering medications for medical conditions, provided such
766 medications are covered under the policy. Such benefits shall be subject
767 to any policy provisions that apply to other services covered by such
768 policy.

769 Sec. 10. Section 38a-518a of the general statutes is repealed and the
770 following is substituted in lieu thereof (*Effective January 1, 2021*):

771 **Sec. 38a-518a. Mandatory coverage for hypodermic needles and**
772 **syringes.** Each group health insurance policy providing coverage of the
773 type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section
774 38a-469, delivered, issued for delivery, renewed, amended or continued
775 in this state shall provide coverage for hypodermic needles or syringes
776 prescribed by a prescribing practitioner, as defined in subdivision [(22)]
777 (24) of section 20-571, for the purpose of administering medications for
778 medical conditions, provided such medications are covered under the
779 policy. Such benefits shall be subject to any policy provisions that apply
780 to other services covered by such policy.

781 Sec. 11. Subdivision (1) of subsection (b) of section 53a-13 of the 2020
782 supplement to the general statutes is repealed and the following is
783 substituted in lieu thereof (*Effective January 1, 2021*):

784 **From 2020 Supplement**

785 (b) (1) It shall not be a defense under this section if such mental
786 disease or defect was proximately caused by the voluntary ingestion,
787 inhalation or injection of intoxicating liquor or any drug or substance,
788 or any combination thereof, unless such drug was prescribed for the
789 defendant by a prescribing practitioner, as defined in subdivision [(22)]
790 (24) of section 20-571, and was used in accordance with the directions of

791 such prescription.

792 Sec. 12. Subsection (l) of section 20-619 of the general statutes is
793 repealed and the following is substituted in lieu thereof (*Effective January*
794 *1, 2021*):

795 (l) Upon the initial filling or renewal of a prescription that contains a
796 statistical information code based upon the most recent edition of the
797 International Classification of Diseases indicating the prescribed drug is
798 used for the treatment of epilepsy or to prevent seizures, a pharmacist
799 shall not fill the prescription by using a different drug manufacturer or
800 distributor of the prescribed drug or biological product, unless the
801 pharmacist (1) provides prior notice of the use of a different drug or
802 biological product manufacturer or distributor to the patient and the
803 prescribing practitioner, and (2) obtains the written consent of the
804 patient's prescribing practitioner. For purposes of obtaining the consent
805 of the patient's prescribing practitioner required by this subsection, a
806 pharmacist shall notify the prescribing practitioner via electronic mail
807 or facsimile transmission. If the prescribing practitioner does not
808 provide the necessary consent, the pharmacist shall fill the prescription
809 without such substitution or use of a different drug or biological
810 product manufacturer or distributor or return the prescription to the
811 patient or to the patient's representative for filling at another pharmacy.
812 If a pharmacist is unable to contact the patient's prescribing practitioner
813 after making reasonable efforts to do so, such pharmacist may exercise
814 professional judgment in refilling a prescription in accordance with the
815 provisions of subsection [(b)] (c) of section 20-616. For purposes of this
816 subsection, "pharmacy" means a place of business where drugs and
817 devices may be sold at retail and for which a pharmacy license was
818 issued pursuant to section 20-594, including a hospital-based pharmacy
819 when such pharmacy is filling prescriptions for employees and
820 outpatient care, and a mail order pharmacy licensed by this state to
821 distribute in this state. "Pharmacy" does not include a pharmacy serving
822 patients in a long-term care facility, other institutional facility or a

DRAFT

Bill No.

823 pharmacy that provides prescriptions for inpatient hospitals.

824 Sec. 13. Section 38a-492d of the general statutes is repealed and the
825 following is substituted in lieu thereof (*Effective January 1, 2021*):

826 (a) For the purposes of this section:

827 (1) "Diabetes equipment and supplies" means equipment and
828 supplies that are used to treat diabetes, including, but not limited to,
829 blood glucose test strips, glucometers, lancets, lancing devices and
830 insulin syringes;

831 (2) "High deductible health plan" has the same meaning as that term
832 is used in subsection (f) of section 38a-493;

833 (3) "Insulin drug" means a drug, including, but not limited to, an
834 insulin pen, that contains insulin, is prescribed for self-administration
835 on an outpatient basis and approved by the federal Food and Drug
836 Administration to treat diabetes;

837 (4) "Noninsulin drug" means a drug, including, but not limited to,
838 glucagon, a glucose tablet or glucose gel, that does not contain insulin
839 and is approved by the federal Food and Drug Administration to treat
840 diabetes; and

841 (5) "Prescribing practitioner" has the same meaning as provided in
842 section 20-571.

843 [(a) Each] (b) Notwithstanding the provisions of section 38a-492a,
844 each individual health insurance policy providing coverage of the type
845 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
846 delivered, issued for delivery, [or] renewed, amended or continued in
847 this state shall provide coverage for [laboratory] the treatment of all
848 types of diabetes. Such coverage shall include, but need not be limited
849 to, coverage for medically necessary:

DRAFT

Bill No.

850 (1) Laboratory and diagnostic [tests] testing and screening, including,
851 but not limited to, hemoglobin A1c testing and retinopathy screening,
852 for all types of diabetes;

853 (2) Insulin drugs (A) prescribed by a prescribing practitioner, or (B)
854 prescribed and dispensed pursuant to subsection (d) of section 20-616
855 once during any policy year;

856 (3) Noninsulin drugs prescribed by a prescribing practitioner; and

857 (4) Diabetes equipment and supplies in accordance with the insured's
858 diabetes treatment plan, including, but not limited to, diabetes
859 equipment and supplies prescribed and dispensed pursuant to
860 subsection (d) of section 20-616 once during any policy year.

861 [(b) Notwithstanding the provisions of section 38a-492a, each
862 individual health insurance policy providing coverage of the type
863 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
864 delivered, issued for delivery or renewed in this state shall provide
865 medically necessary coverage for the treatment of insulin-dependent
866 diabetes, insulin-using diabetes, gestational diabetes and non-insulin-
867 using diabetes. Such coverage shall include medically necessary
868 equipment, in accordance with the insured person's treatment plan,
869 drugs and supplies prescribed by a prescribing practitioner, as defined
870 in section 20-571.]

871 (c) (1) Notwithstanding the provisions of section 38a-492a and except
872 as provided in subdivision (2) of this subsection, no policy described in
873 subsection (b) of this section shall impose coinsurance, copayments,
874 deductibles and other out-of-pocket expenses on an insured that exceed:

875 (A) Twenty-five dollars for each thirty-day supply of a medically
876 necessary covered insulin drug (A) prescribed to the insured by a
877 prescribing practitioner, or (B) prescribed and dispensed pursuant to
878 subsection (d) of section 20-616 once during any policy year;

DRAFT

Bill No.

879 (B) Twenty-five dollars for each thirty-day supply of a medically
880 necessary covered noninsulin drug prescribed to the insured by a
881 prescribing practitioner; or

882 (C) One hundred dollars for a thirty-day supply of all medically
883 necessary covered diabetes equipment and supplies for such insured
884 that are in accordance with such insured's diabetes treatment plan,
885 including, but not limited to, diabetes equipment and supplies
886 prescribed and dispensed pursuant to subsection (d) of section 20-616
887 once during any policy year.

888 (2) During any thirty-day period, the combined coinsurance,
889 copayments, deductibles and other out-of-pocket expenses for all
890 medically necessary covered insulin drugs prescribed to an insured for
891 such period and all medically necessary covered diabetes equipment
892 and supplies for the insured for such period shall not exceed one
893 hundred dollars, provided such diabetes equipment and supplies are in
894 accordance with such insured's diabetes treatment plan.

895 (d) The provisions of subsection (c) of this section shall apply to a
896 high deductible health plan to the maximum extent permitted by federal
897 law, except if such plan is used to establish a medical savings account
898 or an Archer MSA pursuant to Section 220 of the Internal Revenue Code
899 of 1986, or any subsequent corresponding internal revenue code of the
900 United States, as amended from time to time, or a health savings account
901 pursuant to Section 223 of said Internal Revenue Code, as amended
902 from time to time, the provisions of said subsection (c) shall apply to
903 such plan to the maximum extent that (1) is permitted by federal law,
904 and (2) does not disqualify such account for the deduction allowed
905 under said Section 220 or 223, as applicable.

906 Sec. 14. Section 38a-518d of the general statutes is repealed and the
907 following is substituted in lieu thereof (*Effective January 1, 2021*):

908 (a) For the purposes of this section:

DRAFT

Bill No.

909 (1) "Diabetes equipment and supplies" means equipment and
910 supplies that are used to treat diabetes, including, but not limited to,
911 blood glucose test strips, glucometers, lancets, lancing devices and
912 insulin syringes;

913 (2) "High deductible health plan" has the same meaning as that term
914 is used in subsection (f) of section 38a-520;

915 (3) "Insulin drug" means a drug, including, but not limited to, an
916 insulin pen, that contains insulin, is prescribed for self-administration
917 on an outpatient basis and approved by the federal Food and Drug
918 Administration to treat diabetes;

919 (4) "Noninsulin drug" means a drug, including, but not limited to,
920 glucagon, a glucose tablet or glucose gel, that does not contain insulin
921 and is approved by the federal Food and Drug Administration to treat
922 diabetes; and

923 (5) "Prescribing practitioner" has the same meaning as provided in
924 section 20-571.

925 [(a) Each] (b) Notwithstanding the provisions of section 38a-518a,
926 each group health insurance policy providing coverage of the type
927 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
928 delivered, issued for delivery, [or] renewed, amended or continued in
929 this state shall provide coverage for [laboratory] the treatment of all
930 types of diabetes. Such coverage shall include, but need not be limited
931 to, coverage for medically necessary:

932 (1) Laboratory and diagnostic [tests] testing and screening, including,
933 but not limited to, hemoglobin A1c testing and retinopathy screening,
934 for all types of diabetes;

935 (2) Insulin drugs (A) prescribed by a prescribing practitioner, or (B)
936 prescribed and dispensed pursuant to subsection (d) of section 20-616

937 once during any policy year;

938 (3) Noninsulin drugs prescribed by a prescribing practitioner; and

939 (4) Diabetes equipment and supplies in accordance with the insured's
940 diabetes treatment plan, including, but not limited to, diabetes
941 equipment and supplies prescribed and dispensed pursuant to
942 subsection (d) of section 20-616 once during any policy year.

943 [(b) Notwithstanding the provisions of section 38a-518a, each group
944 health insurance policy providing coverage of the type specified in
945 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered,
946 issued for delivery or renewed in this state shall provide medically
947 necessary coverage for the treatment of insulin-dependent diabetes,
948 insulin-using diabetes, gestational diabetes and non-insulin-using
949 diabetes. Such coverage shall include medically necessary equipment,
950 in accordance with the insured person's treatment plan, drugs and
951 supplies prescribed by a prescribing practitioner, as defined in section
952 20-571.]

953 (c) (1) Notwithstanding the provisions of section 38a-518a and except
954 as provided in subdivision (2) of this subsection, no policy described in
955 subsection (b) of this section shall impose coinsurance, copayments,
956 deductibles and other out-of-pocket expenses on an insured that exceed:

957 (A) Twenty-five dollars for each thirty-day supply of a medically
958 necessary covered insulin drug (A) prescribed to the insured by a
959 prescribing practitioner, or (B) prescribed and dispensed pursuant to
960 subsection (d) of section 20-616 once during any policy year;

961 (B) Twenty-five dollars for each thirty-day supply of a medically
962 necessary covered noninsulin drug prescribed to the insured by a
963 prescribing practitioner; or

964 (C) One hundred dollars for a thirty-day supply of all medically

DRAFT

Bill No.

965 necessary covered diabetes equipment and supplies for such insured
966 that are in accordance with such insured's diabetes treatment plan,
967 including, but not limited to, diabetes equipment and supplies
968 prescribed and dispensed pursuant to subsection (d) of section 20-616
969 once during any policy year.

970 (2) During any thirty-day period, the combined coinsurance,
971 copayments, deductibles and other out-of-pocket expenses for all
972 medically necessary covered insulin drugs prescribed to an insured for
973 such period and all medically necessary covered diabetes equipment
974 and supplies for the insured for such period shall not exceed one
975 hundred dollars, provided such diabetes equipment and supplies are in
976 accordance with such insured's diabetes treatment plan.

977 (d) The provisions of subsection (c) of this section shall apply to a
978 high deductible health plan to the maximum extent permitted by federal
979 law, except if such plan is used to establish a medical savings account
980 or an Archer MSA pursuant to Section 220 of the Internal Revenue Code
981 of 1986, or any subsequent corresponding internal revenue code of the
982 United States, as amended from time to time, or a health savings account
983 pursuant to Section 223 of said Internal Revenue Code, as amended
984 from time to time, the provisions of said subsection (c) shall apply to
985 such plan to the maximum extent that (1) is permitted by federal law,
986 and (2) does not disqualify such account for the deduction allowed
987 under said Section 220 or 223, as applicable.

988 Sec. 15. Subsection (f) of section 38a-493 of the general statutes is
989 repealed and the following is substituted in lieu thereof (*Effective October*
990 *1, 2020*):

991 (f) Home health care benefits may be subject to an annual deductible
992 of not more than fifty dollars for each person covered under a policy
993 and may be subject to a coinsurance provision that provides for
994 coverage of not less than seventy-five per cent of the reasonable charges

DRAFT

Bill No.

995 for such services. Such policy may also contain reasonable limitations
996 and exclusions applicable to home health care coverage. A high
997 deductible health plan, as defined in Section 220(c)(2) or Section
998 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent
999 corresponding internal revenue code of the United States, as amended
1000 from time to time, used to establish a medical savings account or an
1001 Archer MSA pursuant to Section 220 of said Internal Revenue Code or a
1002 health savings account pursuant to Section 223 of said Internal Revenue
1003 Code shall not be subject to the deductible limits set forth in this
1004 subsection.

1005 Sec. 16. Subsection (b) of section 38a-490a of the general statutes is
1006 repealed and the following is substituted in lieu thereof (*Effective October*
1007 *1, 2020*):

1008 (b) No such policy shall impose a coinsurance, copayment, deductible
1009 or other out-of-pocket expense for such services, except that a high
1010 deductible health plan, as that term is used in subsection (f) of section
1011 38a-493, shall not be subject to the deductible limits set forth in this
1012 section.

1013 Sec. 17. Subdivision (2) of subsection (b) of section 38a-492k of the
1014 general statutes is repealed and the following is substituted in lieu
1015 thereof (*Effective October 1, 2020*):

1016 (2) A coinsurance, copayment, deductible or other out-of-pocket
1017 expense for any additional colonoscopy ordered in a policy year by a
1018 physician for an insured. The provisions of this subdivision shall not
1019 apply to a high deductible health plan as that term is used in subsection
1020 (f) of section 38a-493.

1021 Sec. 18. Subsection (b) of section 38a-492o of the general statutes is
1022 repealed and the following is substituted in lieu thereof (*Effective October*
1023 *1, 2020*):

DRAFT

Bill No.

1024 (b) No such policy shall impose a coinsurance, copayment, deductible
1025 or other out-of-pocket expense for such testing in excess of twenty per
1026 cent of the cost for such testing per year. The provisions of this
1027 subsection shall not apply to a high deductible health plan as that term
1028 is used in subsection (f) of section 38a-493.

1029 Sec. 19. Subsection (b) of section 38a-492r of the general statutes is
1030 repealed and the following is substituted in lieu thereof (*Effective October*
1031 *1, 2020*):

1032 (b) No policy described in subsection (a) of this section shall impose
1033 a coinsurance, copayment, deductible or other out-of-pocket expense for
1034 the benefits and services required under said subsection. The provisions
1035 of this subsection shall apply to a high deductible health plan, as that
1036 term is used in subsection (f) of section 38a-493, to the maximum extent
1037 permitted by federal law, except if such plan is used to establish a
1038 medical savings account or an Archer MSA pursuant to Section 220 of
1039 the Internal Revenue Code of 1986, or any subsequent corresponding
1040 internal revenue code of the United States, as amended from time to
1041 time, or a health savings account [, as that term is used in] pursuant to
1042 Section 223 of [the] said Internal Revenue Code, [of 1986 or any
1043 subsequent corresponding internal revenue code of the United States,]
1044 as amended from time to time, the provisions of this subsection shall
1045 apply to such plan to the maximum extent that (1) is permitted by
1046 federal law, and (2) does not disqualify such account for the deduction
1047 allowed under said Section 220 or 223, as applicable. Nothing in this
1048 section shall preclude a policy that provides the coverage required
1049 under subsection (a) of this section and uses a provider network from
1050 imposing cost-sharing requirements for any benefit or service required
1051 under said subsection (a) that is delivered by an out-of-network
1052 provider.

1053 Sec. 20. Subsection (b) of section 38a-492s of the general statutes is
1054 repealed and the following is substituted in lieu thereof (*Effective October*

1055 1, 2020):

1056 (b) No such policy shall impose a coinsurance, copayment, deductible
1057 or other out-of-pocket expense for the benefits and services required
1058 under subsection (a) of this section. The provisions of this subsection
1059 shall apply to a high deductible health plan, as that term is used in
1060 subsection (f) of section 38a-493, to the maximum extent permitted by
1061 federal law, except if such plan is used to establish a medical savings
1062 account or an Archer MSA pursuant to Section 220 of the Internal
1063 Revenue Code of 1986, or any subsequent corresponding internal
1064 revenue code of the United States, as amended from time to time, or a
1065 health savings account [, as that term is used in] pursuant to Section 223
1066 of [the] said Internal Revenue Code, [of 1986 or any subsequent
1067 corresponding internal revenue code of the United States,] as amended
1068 from time to time, the provisions of this subsection shall apply to such
1069 plan to the maximum extent that (1) is permitted by federal law, and (2)
1070 does not disqualify such account for the deduction allowed under said
1071 Section 220 or 223, as applicable. Nothing in this section shall preclude
1072 a policy that provides the coverage required under subsection (a) of this
1073 section and uses a provider network from imposing cost-sharing
1074 requirements for any benefit or service required under said subsection
1075 (a) that is delivered by an out-of-network provider.

1076 Sec. 21. Subdivision (3) of subsection (b) of section 38a-492t of the
1077 general statutes is repealed and the following is substituted in lieu
1078 thereof (*Effective October 1, 2020*):

1079 (3) No such policy shall impose a coinsurance, copayment, deductible
1080 or other out-of-pocket expense for a prosthetic device that is more
1081 restrictive than that imposed on substantially all other benefits provided
1082 under such policy, except that a high deductible health plan, as that term
1083 is used in subsection (f) of section 38a-493, shall not be subject to the
1084 deductible limits set forth in this subdivision or under Medicare
1085 pursuant to subdivision (1) of this subsection.

1086 Sec. 22. Subsection (c) of section 38a-503 of the 2020 supplement to
1087 the general statutes is repealed and the following is substituted in lieu
1088 thereof (*Effective October 1, 2020*):

1089 (c) Benefits under this section shall be subject to any policy provisions
1090 that apply to other services covered by such policy, except that no such
1091 policy shall impose a coinsurance, copayment, deductible or other out-
1092 of-pocket expense for such benefits. The provisions of this subsection
1093 shall apply to a high deductible health plan, as that term is used in
1094 subsection (f) of section 38a-493, to the maximum extent permitted by
1095 federal law, except if such plan is used to establish a medical savings
1096 account or an Archer MSA pursuant to Section 220 of the Internal
1097 Revenue Code of 1986 or any subsequent corresponding internal
1098 revenue code of the United States, as amended from time to time, or a
1099 health savings account pursuant to Section 223 of said Internal Revenue
1100 Code, as amended from time to time, the provisions of this subsection
1101 shall apply to such plan to the maximum extent that (1) is permitted by
1102 federal law, and (2) does not disqualify such account for the deduction
1103 allowed under said Section 220 or 223, as applicable.

1104 Sec. 23. Subsection (b) of section 38a-503e of the general statutes is
1105 repealed and the following is substituted in lieu thereof (*Effective October*
1106 *1, 2020*):

1107 (b) No policy described in subsection (a) of this section shall impose
1108 a coinsurance, copayment, deductible or other out-of-pocket expense for
1109 the benefits and services required under said subsection (a), except that
1110 any such policy that uses a provider network may require cost-sharing
1111 when such benefits and services are rendered by an out-of-network
1112 provider. The cost-sharing limits imposed under this subsection shall
1113 apply to a high deductible health plan, as that term is used in subsection
1114 (f) of section 38a-493, to the maximum extent permitted by federal law,
1115 except if such plan is used to establish a medical savings account or an
1116 Archer MSA pursuant to Section 220 of the Internal Revenue Code of

DRAFT

Bill No.

1117 1986 or any subsequent corresponding internal revenue code of the
1118 United States, as amended from time to time, or a health savings account
1119 [, as that term is used in] pursuant to Section 223 of [the] said Internal
1120 Revenue Code, [of 1986 or any subsequent corresponding internal
1121 revenue code of the United States,] as amended from time to time, the
1122 provisions of this subsection shall apply to such plan to the maximum
1123 extent that (1) is permitted by federal law, and (2) does not disqualify
1124 such account for the deduction allowed under said Section 220 or 223,
1125 as applicable.

1126 Sec. 24. Subsection (b) of section 38a-503f of the general statutes is
1127 repealed and the following is substituted in lieu thereof (*Effective October*
1128 *1, 2020*):

1129 (b) No policy described in subsection (a) of this section shall impose
1130 a coinsurance, copayment, deductible or other out-of-pocket expense for
1131 the benefits and services required under said subsection. The provisions
1132 of this subsection shall apply to a high deductible health plan, as that
1133 term is used in subsection (f) of section 38a-493, to the maximum extent
1134 permitted by federal law, except if such plan is used to establish a
1135 medical savings account or an Archer MSA pursuant to Section 220 of
1136 the Internal Revenue Code of 1986 or any subsequent corresponding
1137 internal revenue code of the United States, as amended from time to
1138 time, or a health savings account [, as that term is used in] pursuant to
1139 Section 223 of [the] said Internal Revenue Code, [of 1986 or any
1140 subsequent corresponding internal revenue code of the United States,]
1141 as amended from time to time, the provisions of this subsection shall
1142 apply to such plan to the maximum extent that (1) is permitted by
1143 federal law, and (2) does not disqualify such account for the deduction
1144 allowed under said Section 220 or 223, as applicable. Nothing in this
1145 section shall preclude a policy that provides the coverage required
1146 under subsection (a) of this section and uses a provider network from
1147 imposing cost-sharing requirements for any benefit or service required
1148 under said subsection (a) that is delivered by an out-of-network

1149 provider.

1150 Sec. 25. Subsection (c) of section 38a-511 of the general statutes is
1151 repealed and the following is substituted in lieu thereof (*Effective October*
1152 *1, 2020*):

1153 (c) The provisions of subsections (a) and (b) of this section shall not
1154 apply to a high deductible health plan as that term is used in subsection
1155 (f) of section 38a-493.

1156 Sec. 26. Subsection (f) of section 38a-520 of the general statutes is
1157 repealed and the following is substituted in lieu thereof (*Effective October*
1158 *1, 2020*):

1159 (f) Home health care benefits may be subject to an annual deductible
1160 of not more than fifty dollars for each person covered under a policy
1161 and may be subject to a coinsurance provision that provides for
1162 coverage of not less than seventy-five per cent of the reasonable charges
1163 for such services. Such policy may also contain reasonable limitations
1164 and exclusions applicable to home health care coverage. A high
1165 deductible health plan, as defined in Section 220(c)(2) or Section
1166 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent
1167 corresponding internal revenue code of the United States, as amended
1168 from time to time, used to establish a medical savings account or an
1169 Archer MSA pursuant to Section 220 of said Internal Revenue Code or a
1170 health savings account pursuant to Section 223 of said Internal Revenue
1171 Code shall not be subject to the deductible limits set forth in this
1172 subsection.

1173 Sec. 27. Subsection (b) of section 38a-516a of the general statutes is
1174 repealed and the following is substituted in lieu thereof (*Effective October*
1175 *1, 2020*):

1176 (b) No such policy shall impose a coinsurance, copayment, deductible
1177 or other out-of-pocket expense for such services, except that a high

DRAFT

Bill No.

1178 deductible health plan, as that term is used in subsection (f) of section
1179 38a-520, shall not be subject to the deductible limits set forth in this
1180 section.

1181 Sec. 28. Subdivision (2) of subsection (b) of section 38a-518k of the
1182 general statutes is repealed and the following is substituted in lieu
1183 thereof (*Effective October 1, 2020*):

1184 (2) A coinsurance, copayment, deductible or other out-of-pocket
1185 expense for any additional colonoscopy ordered in a policy year by a
1186 physician for an insured. The provisions of this subdivision shall not
1187 apply to a high deductible health plan as that term is used in subsection
1188 (f) of section 38a-520.

1189 Sec. 29. Subsection (b) of section 38a-518o of the general statutes is
1190 repealed and the following is substituted in lieu thereof (*Effective October*
1191 *1, 2020*):

1192 (b) No such policy shall impose a coinsurance, copayment, deductible
1193 or other out-of-pocket expense for such testing in excess of twenty per
1194 cent of the cost for such testing per year. The provisions of this
1195 subsection shall not apply to a high deductible health plan as that term
1196 is used in subsection (f) of section 38a-520.

1197 Sec. 30. Subsection (b) of section 38a-518r of the general statutes is
1198 repealed and the following is substituted in lieu thereof (*Effective October*
1199 *1, 2020*):

1200 (b) No policy described in subsection (a) of this section shall impose
1201 a coinsurance, copayment, deductible or other out-of-pocket expense for
1202 the benefits and services required under said subsection. The provisions
1203 of this subsection shall apply to a high deductible health plan, as that
1204 term is used in subsection (f) of section [38a-493] 38a-520, to the
1205 maximum extent permitted by federal law, except if such plan is used
1206 to establish a medical savings account or an Archer MSA pursuant to

DRAFT

Bill No.

1207 Section 220 of the Internal Revenue Code of 1986 or any subsequent
1208 corresponding internal revenue code of the United States, as amended
1209 from time to time, or a health savings account [, as that term is used in]
1210 pursuant to Section 223 of [the] said Internal Revenue Code, [of 1986 or
1211 any subsequent corresponding internal revenue code of the United
1212 States,] as amended from time to time, the provisions of this subsection
1213 shall apply to such plan to the maximum extent that (1) is permitted by
1214 federal law, and (2) does not disqualify such account for the deduction
1215 allowed under said Section 220 or 223, as applicable. Nothing in this
1216 section shall preclude a policy that provides the coverage required
1217 under subsection (a) of this section and uses a provider network from
1218 imposing cost-sharing requirements for any benefit or service required
1219 under said subsection (a) that is delivered by an out-of-network
1220 provider.

1221 Sec. 31. Subsection (b) of section 38a-518s of the general statutes is
1222 repealed and the following is substituted in lieu thereof (*Effective October*
1223 *1, 2020*):

1224 (b) No such policy shall impose a coinsurance, copayment, deductible
1225 or other out-of-pocket expense for the benefits and services required
1226 under subsection (a) of this section. The provisions of this subsection
1227 shall apply to a high deductible health plan, as that term is used in
1228 subsection (f) of section [38a-493] 38a-520, to the maximum extent
1229 permitted by federal law, except if such plan is used to establish a
1230 medical savings account or an Archer MSA pursuant to Section 220 of
1231 the Internal Revenue Code of 1986 or any subsequent corresponding
1232 internal revenue code of the United States, as amended from time to
1233 time, or a health savings account [, as that term is used in] pursuant to
1234 Section 223 of [the] said Internal Revenue Code, [of 1986 or any
1235 subsequent corresponding internal revenue code of the United States,]
1236 as amended from time to time, the provisions of this subsection shall
1237 apply to such plan to the maximum extent that (1) is permitted by
1238 federal law, and (2) does not disqualify such account for the deduction

DRAFT

Bill No.

1239 allowed under said Section 220 or 223, as applicable. Nothing in this
1240 section shall preclude a policy that provides the coverage required
1241 under subsection (a) of this section and uses a provider network from
1242 imposing cost-sharing requirements for any benefit or service required
1243 under said subsection (a) that is delivered by an out-of-network
1244 provider.

1245 Sec. 32. Subdivision (3) of subsection (b) of section 38a-518t of the
1246 general statutes is repealed and the following is substituted in lieu
1247 thereof (*Effective October 1, 2020*):

1248 (3) No such policy shall impose a coinsurance, copayment, deductible
1249 or other out-of-pocket expense for a prosthetic device that is more
1250 restrictive than that imposed on substantially all other benefits provided
1251 under such policy, except that a high deductible health plan, as that term
1252 is used in subsection (f) of section 38a-520, shall not be subject to the
1253 deductible limits set forth in this subdivision or under Medicare
1254 pursuant to subdivision (1) of this subsection.

1255 Sec. 33. Subsection (c) of section 38a-530 of the 2020 supplement to
1256 the general statutes is repealed and the following is substituted in lieu
1257 thereof (*Effective October 1, 2020*):

1258 (c) Benefits under this section shall be subject to any policy provisions
1259 that apply to other services covered by such policy, except that no such
1260 policy shall impose a coinsurance, copayment, deductible or other out-
1261 of-pocket expense for such benefits. The provisions of this subsection
1262 shall apply to a high deductible health plan, as that term is used in
1263 subsection (f) of section 38a-520, to the maximum extent permitted by
1264 federal law, except if such plan is used to establish a medical savings
1265 account or an Archer MSA pursuant to Section 220 of the Internal
1266 Revenue Code of 1986 or any subsequent corresponding internal
1267 revenue code of the United States, as amended from time to time, or a
1268 health savings account pursuant to Section 223 of said Internal Revenue

DRAFT

Bill No.

1269 Code, as amended from time to time, the provisions of this subsection
1270 shall apply to such plan to the maximum extent that (1) is permitted by
1271 federal law, and (2) does not disqualify such account for the deduction
1272 allowed under said Section 220 or 223, as applicable.

1273 Sec. 34. Subsection (b) of section 38a-530e of the general statutes is
1274 repealed and the following is substituted in lieu thereof (*Effective October*
1275 *1, 2020*):

1276 (b) No policy described in subsection (a) of this section shall impose
1277 a coinsurance, copayment, deductible or other out-of-pocket expense for
1278 the benefits and services required under said subsection (a), except that
1279 any such policy that uses a provider network may require cost-sharing
1280 when such benefits and services are rendered by an out-of-network
1281 provider. The cost-sharing limits imposed under this subsection shall
1282 apply to a high deductible health plan, as that term is used in subsection
1283 (f) of section [38a-493] 38a-520, to the maximum extent permitted by
1284 federal law, except if such plan is used to establish a medical savings
1285 account or an Archer MSA pursuant to Section 220 of the Internal
1286 Revenue Code of 1986 or any subsequent corresponding internal
1287 revenue code of the United States, as amended from time to time, or a
1288 health savings account [, as that term is used in] pursuant to Section 223
1289 of [the] said Internal Revenue Code, [of 1986 or any subsequent
1290 corresponding internal revenue code of the United States,] as amended
1291 from time to time, the provisions of this subsection shall apply to such
1292 plan to the maximum extent that (1) is permitted by federal law, and (2)
1293 does not disqualify such account for the deduction allowed under said
1294 Section 220 or 223, as applicable.

1295 Sec. 35. Subsection (b) of section 38a-530f of the general statutes is
1296 repealed and the following is substituted in lieu thereof (*Effective October*
1297 *1, 2020*):

1298 (b) No policy described in subsection (a) of this section shall impose

DRAFT

Bill No.

1299 a coinsurance, copayment, deductible or other out-of-pocket expense for
1300 the benefits and services required under said subsection. The provisions
1301 of this subsection shall apply to a high deductible health plan, as that
1302 term is used in subsection (f) of section [38a-493] 38a-520, to the
1303 maximum extent permitted by federal law, except if such plan is used
1304 to establish a medical savings account or an Archer MSA pursuant to
1305 Section 220 of the Internal Revenue Code of 1986 or any subsequent
1306 corresponding internal revenue code of the United States, as amended
1307 from time to time, or a health savings account, as that term is used in
1308 Section 223 of [the] said Internal Revenue Code, [of 1986 or any
1309 subsequent corresponding internal revenue code of the United States,]
1310 as amended from time to time, the provisions of this subsection shall
1311 apply to such plan to the maximum extent that (1) is permitted by
1312 federal law, and (2) does not disqualify such account for the deduction
1313 allowed under said Section 220 or 223, as applicable. Nothing in this
1314 section shall preclude a policy that provides the coverage required
1315 under subsection (a) of this section and uses a provider network from
1316 imposing cost-sharing requirements for any benefit or service required
1317 under said subsection (a) that is delivered by an out-of-network
1318 provider.

1319 Sec. 36. Subsection (c) of section 38a-550 of the general statutes is
1320 repealed and the following is substituted in lieu thereof (*Effective October*
1321 *1, 2020*):

1322 (c) The provisions of subsections (a) and (b) of this section shall not
1323 apply to a high deductible health plan as that term is used in subsection
1324 (f) of section 38a-520.

This act shall take effect as follows and shall amend the following sections:

Section 1	<i>from passage</i>	New section
Sec. 2	<i>January 1, 2021</i>	20-571
Sec. 3	<i>January 1, 2021</i>	20-616

DRAFT

Bill No.

Sec. 4	<i>from passage</i>	New section
Sec. 5	<i>January 1, 2021</i>	21a-254(j)
Sec. 6	<i>January 1, 2021</i>	21a-65(b)
Sec. 7	<i>January 1, 2021</i>	21a-70(a)
Sec. 8	<i>January 1, 2021</i>	21a-249(j)
Sec. 9	<i>January 1, 2021</i>	38a-492a
Sec. 10	<i>January 1, 2021</i>	38a-518a
Sec. 11	<i>January 1, 2021</i>	53a-13(b)(1)
Sec. 12	<i>January 1, 2021</i>	20-619(l)
Sec. 13	<i>January 1, 2021</i>	38a-492d
Sec. 14	<i>January 1, 2021</i>	38a-518d
Sec. 15	<i>October 1, 2020</i>	38a-493(f)
Sec. 16	<i>October 1, 2020</i>	38a-490a(b)
Sec. 17	<i>October 1, 2020</i>	38a-492k(b)(2)
Sec. 18	<i>October 1, 2020</i>	38a-492o(b)
Sec. 19	<i>October 1, 2020</i>	38a-492r(b)
Sec. 20	<i>October 1, 2020</i>	38a-492s(b)
Sec. 21	<i>October 1, 2020</i>	38a-492t(b)(3)
Sec. 22	<i>October 1, 2020</i>	38a-503(c)
Sec. 23	<i>October 1, 2020</i>	38a-503e(b)
Sec. 24	<i>October 1, 2020</i>	38a-503f(b)
Sec. 25	<i>October 1, 2020</i>	38a-511(c)
Sec. 26	<i>October 1, 2020</i>	38a-520(f)
Sec. 27	<i>October 1, 2020</i>	38a-516a(b)
Sec. 28	<i>October 1, 2020</i>	38a-518k(b)(2)
Sec. 29	<i>October 1, 2020</i>	38a-518o(b)
Sec. 30	<i>October 1, 2020</i>	38a-518r(b)
Sec. 31	<i>October 1, 2020</i>	38a-518s(b)
Sec. 32	<i>October 1, 2020</i>	38a-518t(b)(3)
Sec. 33	<i>October 1, 2020</i>	38a-530(c)
Sec. 34	<i>October 1, 2020</i>	38a-530e(b)
Sec. 35	<i>October 1, 2020</i>	38a-530f(b)
Sec. 36	<i>October 1, 2020</i>	38a-550(c)