General Assembly

Bill No. 6003

July Special Session, 2020

LCO No. **3694**

Referred to Committee on No Committee

Introduced by:

REP. ARESIMOWICZ, 30th Dist.
SEN. LOONEY, 11th Dist.
REP. RITTER M., 1st Dist.
SEN. DUFF, 25th Dist.
REP. KLARIDES, 114th Dist.
SEN. FASANO, 34th Dist.

AN ACT CONCERNING DIABETES AND HIGH DEDUCTIBLE HEALTH PLANS.

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

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

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

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

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

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

(5) "Federally-qualified health center" has the same meaning as provided in Section 1905(l)(2)(B) of the Social Security Act, 42 USC 1396d(l)(2)(B), as amended from time to time.

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

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

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

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

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

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

(C) One member appointed by the Senate chairman of the joint standing committee of the General Assembly having cognizance of matters relating to insurance, who shall be an advocate for insulin

coverage or public health;

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

(E) One member appointed by the Senate ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to insurance, who shall have experience with health care equity or be an advocate for the interests of hospitals;

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

(G) The Commissioner of Social Services, or the Commissioner of Social Services' designee;

(H) The Commissioner of Public Health, or the Commissioner of Public Health's designee; and

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

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

(4) The commissioner shall select a chairperson of the working group from among the members of the working group. Such chairperson shall schedule the first meeting of the working group, which shall be held not later than January 11, 2021.

(5) A majority of the members of the working group shall constitute a quorum for the transaction of any business. Any action taken by the

working group shall be by majority vote of the members present.

(6) Not later than May 1, 2021, the working group shall, in accordance with the provisions of section 11-4a of the general statutes, submit its recommendation under subparagraph (A) of subdivision (1) of this subsection and criteria, if any, developed under subparagraph (B) of subdivision (1) of this subsection to the commissioner and the joint standing committee of the General Assembly having cognizance of matters relating to insurance. The working group shall terminate on the date on which the working group submits its recommendation and criteria, if any, pursuant to this subdivision or May 1, 2021, whichever is earlier.

(7) The commissioner may reestablish the working group after the date on which the working group submits its recommendation and criteria, if any, pursuant to subdivision (6) of this subsection or May 1, 2021, whichever is earlier, to develop new criteria described in subparagraph (B) of subdivision (1) of this subsection in accordance with the requirements of subdivisions (1) to (6), inclusive, of this subsection, except as otherwise provided in this subdivision. The commissioner shall send notice to each appointing authority disclosing that the commissioner has reestablished the working group and the date on which the commissioner reestablished the working group. The appointing authorities shall appoint all members of the reestablished working group not later than sixty days after the date on which the commissioner reestablished the working group. The commissioner shall schedule the first meeting of the reestablished working group for a date that is not later than ninety days after the date on which the commissioner reestablished the working group. The reestablished working group shall submit its new criteria to the commissioner and the joint standing committee of the General Assembly having cognizance of matters relating to insurance, in accordance with the provisions of section 11-4a of the general statutes, not later than two hundred forty days after the commissioner reestablished the working group. The reestablished working group shall terminate on the date that it submits

said criteria or on that date that is two hundred forty days after the commissioner reestablished the working group, whichever is later.

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

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

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

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

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

(2) If the commissioner informs the joint standing committee of the General Assembly having cognizance of matters relating to insurance that the commissioner has determined that the goals of the program described in subparagraph (A) of subdivision (1) of subsection (b) of this section would, in the commissioner's judgment, be more successfully accomplished by applying for a Medicaid research and demonstration waiver under Section 1115 of the Social Security Act, as amended from time to time, the commissioner shall apply for such a waiver to establish

said program and, if the Centers for Medicare and Medicaid Services approves the commissioner's waiver application, establish said program in accordance with the terms of such waiver and all federal and state laws governing said program.

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

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

(2) Enable the department to:

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

(B) Disclose to the individual:

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

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

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

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

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

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

As used in sections 20-570 to 20-630, inclusive, unless the context otherwise requires:

(1) "Administer" means the direct application of a drug or device to the body of a patient or research subject by injection, inhalation,

ingestion or any other means;

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

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

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

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

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

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

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

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

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

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

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

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

(13) "Legend device" means a device that is required by applicable federal or state law to be dispensed pursuant only to a prescription or is restricted to use by prescribing practitioners only or that, under federal law, is required to bear either of the following legends: (A) "RX ONLY" IN ACCORDANCE WITH GUIDELINES ESTABLISHED IN THE

FEDERAL FOOD, DRUG AND COSMETIC ACT; or (B) "CAUTION: FEDERAL LAW RESTRICTS THIS DEVICE FOR USE BY OR ON THE ORDER OF A LICENSED VETERINARIAN.";

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[(28)**]** (29) "Virtual manufacturer" means a person who engages in the manufacture of drugs, devices or cosmetics for which such person: (A)

Owns the new drug application or abbreviated new drug application number, if a prescription drug; (B) owns the unique device identification number, as available, for a prescription device; (C) contracts with a contract manufacturing organization for the physical manufacture of the drugs, devices or cosmetics; (D) is not involved in the physical manufacture of the drugs, devices or cosmetics; and (E) at no time takes physical possession of or stores the drugs, devices or cosmetics; and

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

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

(a) As used in this section:

(1) "Diabetes device" means a device, including, but not limited to, a blood glucose test strip, glucometer, continuous glucometer, lancet, lancing device or insulin syringe, that is (A) a legend device or nonlegend device, and (B) used to cure, diagnose, mitigate, prevent or treat diabetes or low blood sugar;

(2) "Diabetic ketoacidosis device" means a device that is (A) a legend or nonlegend device, and (B) used to screen for or prevent diabetic ketoacidosis;

(3) "Glucagon drug" means a drug that contains glucagon and is (A) a legend drug or nonlegend drug, (B) prescribed for self-administration on an outpatient basis, and (C) approved by the federal Food and Drug Administration to treat low blood sugar;

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

diabetes; and

(5) "Usual customary charge to the public" means a charge for a particular prescription made by a provider to the patient group accounting for the largest number of prescriptions not covered by Medicaid, excluding charges made to third-party payors and special discounts offered to individuals, including, but not limited to, senior citizens.

[(a)**]** (b) Except as provided in subsection **[**(b)**]** (c) or (d) of this section, a prescription may be refilled only upon the written, oral or electronically-transmitted order of a prescribing practitioner.

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

(d) (1) (A) Notwithstanding subsection (c) of this section, a pharmacist may immediately prescribe and dispense to a patient not more than a thirty-day supply of an insulin drug or glucagon drug, any diabetes devices that are necessary to administer such supply of such insulin drug or glucagon drug, or diabetic ketoacidosis device if:

(i) The patient informs the pharmacist that the patient has less than a seven-day supply of such insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis device;

(ii) The pharmacist determines, in the pharmacist's professional judgment, that the patient will likely suffer significant physical harm within seven days if the patient does not obtain an additional supply of such insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis device before the expiration of said seven days;

(iii) The pharmacist reviews the electronic prescription drug monitoring program established pursuant to section 21a-254 and determines that no pharmacist prescribed and dispensed a supply of such insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis device to the patient pursuant to this subsection during the twelve-month period immediately preceding, unless:

(I) The pharmacist determines, by contacting the pharmacy that filled the most recent prescription for such insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis device, by examining another prescription database or reviewing the most recent prescription for such insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis device or a prescription label containing the most recent prescription information for such insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis device, that no pharmacist dispensed a supply of such insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis device to the patient pursuant to this subsection during said twelve-month period; or

(II) The electronic prescription drug monitoring program established pursuant to section 21a-254 is unavailable; and

(iv) Not later than seventy-two hours after the pharmacist dispenses such insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis device the pharmacist, or the pharmacist's representative, provides notice to the practitioner who, other than the pharmacist, most recently prescribed such insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis device to the patient.

(B) A pharmacist shall immediately prescribe and dispense to a

patient not more than a thirty-day supply of an insulin drug or glucagon drug, and any diabetes devices that are necessary to administer such supply of the insulin drug or glucagon drug, or diabetic ketoacidosis device if the criteria established in subparagraphs (A)(i) to (A)(iv), inclusive, of this subdivision have been satisfied and the patient pays, or has health insurance coverage, for such insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis device.

(2) No pharmacist who prescribes and dispenses a supply of an insulin drug or glucagon drug, any diabetes devices that are necessary to administer such supply of the insulin drug or glucagon drug, or diabetic ketoacidosis device pursuant to subdivision (1) of this subsection shall require the patient to tender payment to the pharmacist for such supply in an amount that exceeds:

(A) The amount of the coinsurance, copayment, deductible or other out-of-pocket expense that the patient's health insurance coverage imposes for such supply of such insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis device; or

(B) The usual customary charge to the public for such supply of such insulin drug, glucagon drug, diabetes devices or diabetes ketoacidosis device if the patient does not have health insurance coverage for such supply of such insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis device.

(3) Nothing in subdivision (1) or (2) of this subsection shall be construed to prohibit a pharmacist from requiring a patient to submit to the pharmacist, before the pharmacist prescribes or dispenses a supply of an insulin drug or glucagon drug, any diabetes devices necessary to administer such insulin drug or glucagon drug, or diabetic ketoacidosis device pursuant to said subdivisions, proof of health insurance coverage for the patient, personal identification for the patient, contact information for a health care provider providing treatment to the patient, information concerning previous prescriptions issued to the

patient for the insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis device, a sworn statement by the patient stating that the patient is unable to timely obtain the insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis device that the patient is seeking pursuant to this subsection without suffering significant physical harm, and any amount required by the pharmacist under subdivision (2) of this subsection.

(4) Each pharmacist shall refer a patient who requests a supply of an insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis device pursuant to this subsection to a federally-qualified health center if:

(A) The pharmacist determines that the patient does not have health insurance coverage for such supply of such insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis device; or

(B) The patient informs the pharmacist that the patient is concerned that the net cost to the patient for such supply of such insulin drug, glucagon drug, diabetes devices or diabetic ketoacidosis device is unaffordable.

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

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

(2) The pharmacist transferring the prescription shall cancel the original prescription in such pharmacist's records and shall indicate in such records the name of the pharmacy to which the prescription is transferred and the date of the transfer, provided, such cancellation shall not be required in the case of any transfer between pharmacies which electronically access the same prescription records and utilize the

same computer or other electronic prescription transfer system; and

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

Sec. 4. (*Effective from passage*) Not later than October 1, 2020, the Commissioner of Consumer Protection shall send a notice to each pharmacy disclosing the requirements established in subsection (d) of section 20-616 of the general statutes, as amended by section 3 of this act. For the purposes of this section, "pharmacy" has the same meaning as provided in section 20-571 of the general statutes, as amended by section 2 of this act.

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

(j) (1) The commissioner shall, within available appropriations, establish an electronic prescription drug monitoring program to collect, by electronic means, prescription information for schedules II, III, IV and V controlled substances that are dispensed by pharmacies, nonresident pharmacies, as defined in section 20-627, outpatient pharmacies in hospitals or institutions or by any other dispenser. The program shall be designed to provide information regarding the prescription of controlled substances in order to prevent the improper or illegal use of the controlled substances and shall not infringe on the legitimate prescribing of a controlled substance by a prescribing practitioner acting in good faith and in the course of professional

practice.

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

(3) Prior to July 1, 2016, 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 weekly, by electronic means or, if a pharmacy or outpatient pharmacy does not maintain records electronically, in a format approved by the commissioner, the following information for all controlled substance prescriptions dispensed by such pharmacy or outpatient pharmacy: (A) Dispenser identification number; (B) the date the prescription for the controlled substance was filled; (C) the prescription number; (D) whether the prescription for the controlled substance is new or a refill; (E) the national drug code number for the drug dispensed; (F) the amount of the controlled substance dispensed and the number of days' supply of the controlled substance; (G) a patient identification number; (H) the patient's first name, last name and street address, including postal code; (I) the date of birth of the patient; (J) the date the prescription for the controlled substance was issued by the prescribing practitioner and the prescribing practitioner's Drug Enforcement Agency's identification number; and (K) the type of payment.

(4) (A) Except as provided in this subdivision, on and after July 1, 2016, each pharmacy, nonresident pharmacy, as defined in section 20-627, outpatient pharmacy in a hospital or institution, and dispenser shall report to the commissioner by electronic means, in a format approved by the commissioner, the following information for all controlled substance prescriptions dispensed by such pharmacy or outpatient pharmacy immediately upon, but in no event later than the next business day after, dispensing such prescriptions: (i) Dispenser identification number; (ii) the date the prescription for the controlled substance was filled; (iii) the prescription number; (iv) whether the

prescription for the controlled substance is new or a refill; (v) the national drug code number for the drug dispensed; (vi) the amount of the controlled substance dispensed and the number of days' supply of the controlled substance; (vii) a patient identification number; (viii) the patient's first name, last name and street address, including postal code; (ix) the date of birth of the patient; (x) the date the prescription for the controlled substance was issued by the prescribing practitioner and the prescribing practitioner's Drug Enforcement Agency's identification number; and (xi) the type of payment.

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

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

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

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

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

(8) No person or employer shall prohibit, discourage or impede a prescribing practitioner, pharmacist or pharmacist's authorized pharmacy technician from requesting controlled substance prescription information pursuant to this subsection.

(9) Prior to prescribing greater than a seventy-two-hour supply of any controlled substance to any patient, the prescribing practitioner or such practitioner's authorized agent shall review the patient's records in the electronic prescription drug monitoring program established pursuant to this subsection. Whenever a prescribing practitioner prescribes a

controlled substance, other than a schedule V nonnarcotic controlled substance, for the continuous or prolonged treatment of any patient, such prescriber, or such prescriber's authorized agent, shall review, not less than once every ninety days, the patient's records in such prescription drug monitoring program. Whenever a prescribing practitioner prescribes a schedule V nonnarcotic controlled substance, for the continuous or prolonged treatment of any patient, such prescribing practitioner, or such prescribing practitioner's authorized agent, shall review, not less than annually, the patient's records in such prescription drug monitoring program. If such electronic prescription drug monitoring program is not operational, such prescribing practitioner may prescribe greater than a seventy-two-hour supply of a controlled substance to a patient during the time of such program's inoperability, provided such prescribing practitioner or such authorized agent reviews the records of such patient in such program not more than twenty-four hours after regaining access to such program.

(10) (A) A prescribing practitioner may designate an authorized agent to review the electronic prescription drug monitoring program and patient controlled substance prescription information on behalf of the prescribing practitioner. The prescribing practitioner shall ensure that any authorized agent's access to such program and patient controlled substance prescription information is limited to the purposes described in this section and occurs in a manner that protects the confidentiality of information that is accessed through such program. The prescribing practitioner and any authorized agent shall be subject to the provisions of 45 CFR 164.308, as amended from time to time, concerning administrative safeguards for the protection of electronic protected health information. A prescribing practitioner may be subject to disciplinary action for acts of the authorized agent as provided in section 21a-322.

(B) Notwithstanding the provisions of subparagraph (A) of this subdivision, a prescribing practitioner who is employed by or provides professional services to a hospital shall, prior to designating an

authorized agent to review the electronic prescription drug monitoring program and patient controlled substance prescription information on behalf of the prescribing practitioner, (i) submit a request to designate one or more authorized agents for such purposes and a written protocol for oversight of the authorized agent or agents to the commissioner, in the form and manner prescribed by the commissioner, and (ii) receive the commissioner's approval to designate such authorized agent or agents and of such written protocol. Such written protocol shall designate either the hospital's medical director, a hospital department head, who is a prescribing practitioner, or another prescribing practitioner as the person responsible for ensuring that the authorized agent's or agents' access to such program and patient controlled substance prescription information is limited to the purposes described in this section and occurs in a manner that protects the confidentiality of information that is accessed through such program. A hospital medical director, a hospital department head, who is a prescribing practitioner, or another prescribing practitioner designated as the person responsible for overseeing an authorized agent's or agents' access to such program and information in the written protocol approved by the commissioner may be subject to disciplinary action for acts of the authorized agent or agents as provided in section 21a-322. The commissioner may inspect hospital records to determine compliance with written protocols approved in accordance with this section.

(C) A pharmacist may designate a pharmacy technician to access the electronic prescription drug monitoring program and patient controlled substance prescription information on behalf of the pharmacist only for the purposes of facilitating the pharmacist's review of such patient information. The pharmacist shall ensure that any such pharmacy technician's access to such program and patient controlled substance prescription information is limited to the purposes described in this section and occurs in a manner that protects the confidentiality of information that is accessed through such program. The pharmacist and

any authorized pharmacy technician shall be subject to the provisions of 45 CFR 164.308, as amended from time to time, concerning administrative safeguards for the protection of electronic protected health information. A pharmacist may be subject to disciplinary action for acts of the authorized pharmacy technician.

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

(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 for all insulin drugs, glucagon drugs, diabetes devices and diabetic ketoacidosis devices prescribed and dispensed by such pharmacy or outpatient pharmacy. Such pharmacy or outpatient pharmacy shall report such information to the commissioner in a manner that is consistent with the manner in which such pharmacy or outpatient pharmacy reports information for controlled substance prescriptions pursuant to subdivision (4) of this subsection. For the purposes of this subdivision, "insulin drug", "glucagon drug", "diabetes devices" and "diabetic ketoacidosis device" have the same meanings as provided in section 20-616.

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

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

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

(a) As used in this section: (1) "Drugs", "devices" and "cosmetics" have the same meanings as defined in section 21a-92, "wholesaler" or "distributor" means a person, including, but not limited to, a medical device and oxygen provider, a third-party logistics provider, a virtual manufacturer or a virtual wholesale distributor, as such terms are defined in section 20-571, whether within or without the boundaries of the state of Connecticut, who supplies drugs, devices or cosmetics

prepared, produced or packaged by manufacturers, to other wholesalers, manufacturers, distributors, hospitals, prescribing practitioners, as defined in subdivision **[**(22)**]** (24) of section 20-571, pharmacies, federal, state or municipal agencies, clinics or any other person as permitted under subsection (h) of this section, except that: (A) A retail pharmacy or a pharmacy within a licensed hospital that supplies to another such pharmacy a quantity of a noncontrolled drug or a schedule II, III, IV or V controlled substance normally stocked by such pharmacies to provide for the immediate needs of a patient pursuant to a prescription or medication order of an authorized practitioner, (B) a pharmacy within a licensed hospital that supplies drugs to another hospital or an authorized practitioner for research purposes, (C) a retail pharmacy that supplies a limited quantity of a noncontrolled drug or of a schedule II, III, IV or V controlled substance for emergency stock to a practitioner who is a medical director of a chronic and convalescent nursing home, of a rest home with nursing supervision or of a state correctional institution, and (D) a pharmacy within a licensed hospital that contains another hospital wholly within its physical structure that supplies to such contained hospital a quantity of a noncontrolled drug or a schedule II, III, IV, or V controlled substance normally stocked by such hospitals to provide for the needs of a patient, pursuant to a prescription or medication order of an authorized practitioner, receiving inpatient care on a unit that is operated by the contained hospital shall not be deemed a wholesaler under this section; (2) "manufacturer" means (A) a person, whether within or without the boundaries of the state of Connecticut, who produces, prepares, cultivates, grows, propagates, compounds, converts or processes, directly or indirectly, by extraction from substances of natural origin or by means of chemical synthesis or by a combination of extraction and chemical synthesis, or who packages, repackages, labels or relabels a container under such manufacturer's own or any other trademark or label any drug, device or cosmetic for the purpose of selling such items, or (B) a sterile compounding pharmacy, as defined in section 20-633b, that dispenses sterile

pharmaceuticals without a prescription or a patient-specific medical order; (3) "drug", "device" and "cosmetic" have the same meanings as provided in section 21a-92; and (4) "commissioner" means the Commissioner of Consumer Protection or his or her designee.

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

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

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

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

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

Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for hypodermic needles or syringes prescribed by a prescribing practitioner, as defined in subdivision **[**(22)**]** (24) of section 20-571, for the purpose of administering medications for medical conditions, provided such medications are covered under the

policy. Such benefits shall be subject to any policy provisions that apply to other services covered by such policy.

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

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

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

(l) Upon the initial filling or renewal of a prescription that contains a statistical information code based upon the most recent edition of the International Classification of Diseases indicating the prescribed drug is used for the treatment of epilepsy or to prevent seizures, a pharmacist shall not fill the prescription by using a different drug manufacturer or distributor of the prescribed drug or biological product, unless the pharmacist (1) provides prior notice of the use of a different drug or biological product manufacturer or distributor to the patient and the prescribing practitioner, and (2) obtains the written consent of the patient's prescribing practitioner. For purposes of obtaining the consent of the patient's prescribing practitioner required by this subsection, a pharmacist shall notify the prescribing practitioner via electronic mail or facsimile transmission. If the prescribing practitioner does not provide the necessary consent, the pharmacist shall fill the prescription without such substitution or use of a different drug or biological product manufacturer or distributor or return the prescription to the

patient or to the patient's representative for filling at another pharmacy. If a pharmacist is unable to contact the patient's prescribing practitioner after making reasonable efforts to do so, such pharmacist may exercise professional judgment in refilling a prescription in accordance with the provisions of subsection **[**(b)**]** (c) of section 20-616. For purposes of this subsection, "pharmacy" means a place of business where drugs and devices may be sold at retail and for which a pharmacy license was issued pursuant to section 20-594, including a hospital-based pharmacy when such pharmacy is filling prescriptions for employees and outpatient care, and a mail order pharmacy licensed by this state to distribute in this state. "Pharmacy" does not include a pharmacy serving patients in a long-term care facility, other institutional facility or a pharmacy that provides prescriptions for inpatient hospitals.

Sec. 13. Section 38a-492d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) For the purposes of this section:

(1) "Diabetes device" has the same meaning as provided in section 20-616 of the general statutes;

(2) "Diabetic ketoacidosis device" has the same meaning as provided in section 20-616 of the general statutes;

(3) "Glucagon drug" has the same meaning as provided in section 20-616 of the general statutes;

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

(5) "Insulin drug" has the same meaning as provided in section 20-616 of the general statutes;

(6) "Noninsulin drug" means a drug, including, but not limited to, a glucagon drug, glucose tablet or glucose gel, that does not contain insulin and is approved by the federal Food and Drug Administration

to treat diabetes; and

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

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

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

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

(3) Noninsulin drugs (A) prescribed by a prescribing practitioner, or (B) prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year if the noninsulin drug is a glucagon drug;

(4) Diabetes devices in accordance with the insured's diabetes treatment plan, including, but not limited to, diabetes devices prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year; and

(5) Diabetic ketoacidosis devices in accordance with the insured's diabetes treatment plan, including, but not limited to, diabetic ketoacidosis devices prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year.

[(b) Notwithstanding the provisions of section 38a-492a, each individual health insurance policy providing coverage of the type

specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed in this state shall provide medically necessary coverage for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes. Such coverage shall include medically necessary equipment, in accordance with the insured person's treatment plan, drugs and supplies prescribed by a prescribing practitioner, as defined in section 20-571.**]**

(c) Notwithstanding the provisions of section 38a-492a, no policy described in subsection (b) of this section shall impose coinsurance, copayments, deductibles and other out-of-pocket expenses on an insured that exceed:

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

(2) Twenty-five dollars for each thirty-day supply of a medically necessary covered noninsulin drug (A) prescribed to the insured by a prescribing practitioner, or (B) prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year if such noninsulin drug is a glucagon drug;

(3) One hundred dollars for a thirty-day supply of all medically necessary covered diabetes devices and diabetic ketoacidosis devices for such insured that are in accordance with such insured's diabetes treatment plan, including, but not limited to, diabetes devices and diabetic ketoacidosis devices prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year.

(d) The provisions of subsection (c) of this section shall apply to a high deductible health plan to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code

of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account pursuant to Section 223 of said Internal Revenue Code, as amended from time to time, the provisions of said subsection (c) shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable.

Sec. 14. Section 38a-518d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) For the purposes of this section:

(1) "Diabetes device" has the same meaning as provided in section 20-616 of the general statutes;

(2) "Diabetic ketoacidosis device" has the same meaning as provided in section 20-616 of the general statutes;

(3) "Glucagon drug" has the same meaning as provided in section 20-616 of the general statutes;

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

(5) "Insulin drug" has the same meaning as provided in section 20-616 of the general statutes;

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

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

[(a) Each**]** (b) Notwithstanding the provisions of section 38a-518a,

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

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

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

(3) Noninsulin drugs (A) prescribed by a prescribing practitioner, or (B) prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year if the noninsulin drug is a glucagon drug;

(4) Diabetes devices in accordance with the insured's diabetes treatment plan, including, but not limited to, diabetes devices prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year; and

(5) Diabetic ketoacidosis devices in accordance with the insured's diabetes treatment plan, including, but not limited to, diabetic ketoacidosis devices prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year.

[(b) Notwithstanding the provisions of section 38a-518a, each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed in this state shall provide medically necessary coverage for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes. Such coverage shall include medically necessary equipment,

in accordance with the insured person's treatment plan, drugs and supplies prescribed by a prescribing practitioner, as defined in section 20-571.**]**

(c) Notwithstanding the provisions of section 38a-518a, no policy described in subsection (b) of this section shall impose coinsurance, copayments, deductibles and other out-of-pocket expenses on an insured that exceed:

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

(2) Twenty-five dollars for each thirty-day supply of a medically necessary covered noninsulin drug (A) prescribed to the insured by a prescribing practitioner, or (B) prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year if such noninsulin drug is a glucagon drug;

(3) One hundred dollars for a thirty-day supply of all medically necessary covered diabetes devices and diabetic ketoacidosis devices for such insured that are in accordance with such insured's diabetes treatment plan, including, but not limited to, diabetes devices and diabetic ketoacidosis devices prescribed and dispensed pursuant to subsection (d) of section 20-616 once during a policy year.

(d) The provisions of subsection (c) of this section shall apply to a high deductible health plan to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account pursuant to Section 223 of said Internal Revenue Code, as amended from time to time, the provisions of said subsection (c) shall apply to such plan to the maximum extent that (1) is permitted by federal law,

and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable.

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

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

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

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

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

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

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

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

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

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

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

Sec. 20. Subsection (b) of section 38a-492s of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

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

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

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

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

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

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

(b) No policy described in subsection (a) of this section shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under said subsection (a), except that

any such policy that uses a provider network may require cost-sharing when such benefits and services are rendered by an out-of-network provider. The cost-sharing limits imposed under this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section 38a-493, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account **[**, as that term is used in**]** pursuant to Section 223 of **[**the**]** said Internal Revenue Code, **[**of 1986 or any subsequent corresponding internal revenue code of the United States,**]** as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable.

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

(b) No policy described in subsection (a) of this section shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under said subsection. The provisions of this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section 38a-493, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account **[**, as that term is used in**]** pursuant to Section 223 of **[**the**]** said Internal Revenue Code, **[**of 1986 or any subsequent corresponding internal revenue code of the United States,**]** as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by

federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable. Nothing in this section shall preclude a policy that provides the coverage required under subsection (a) of this section and uses a provider network from imposing cost-sharing requirements for any benefit or service required under said subsection (a) that is delivered by an out-of-network provider.

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

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

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

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

Sec. 27. Subsection (b) of section 38a-516a of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such services, except that a high deductible health plan, as that term is used in subsection (f) of section 38a-520, shall not be subject to the deductible limits set forth in this section.

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

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

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

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

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

(b) No policy described in subsection (a) of this section shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under said subsection. The provisions

of this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section **[**38a-493**]** 38a-520, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account **[**, as that term is used in**]** pursuant to Section 223 of **[**the**]** said Internal Revenue Code, **[**of 1986 or any subsequent corresponding internal revenue code of the United States,**]** as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable. Nothing in this section shall preclude a policy that provides the coverage required under subsection (a) of this section and uses a provider network from imposing cost-sharing requirements for any benefit or service required under said subsection (a) that is delivered by an out-of-network provider.

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

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under subsection (a) of this section. The provisions of this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section **[**38a-493**]** 38a-520, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account **[**, as that term is used in**]** pursuant to Section 223 of **[**the**]** said Internal Revenue Code, **[**of 1986 or any subsequent corresponding internal revenue code of the United States,**]**

as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable. Nothing in this section shall preclude a policy that provides the coverage required under subsection (a) of this section and uses a provider network from imposing cost-sharing requirements for any benefit or service required under said subsection (a) that is delivered by an out-of-network provider.

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

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

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

(c) Benefits under this section shall be subject to any policy provisions that apply to other services covered by such policy, except that no such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such benefits. The provisions of this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section 38a-520, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or any subsequent corresponding internal

revenue code of the United States, as amended from time to time, or a health savings account pursuant to Section 223 of said Internal Revenue Code, as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable.

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

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

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

(b) No policy described in subsection (a) of this section shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under said subsection. The provisions of this subsection shall apply to a high deductible health plan, as that term is used in subsection (f) of section **[**38a-493**]** 38a-520, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account, as that term is used in Section 223 of **[**the**]** said Internal Revenue Code, **[**of 1986 or any subsequent corresponding internal revenue code of the United States,**]** as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223, as applicable. Nothing in this section shall preclude a policy that provides the coverage required under subsection (a) of this section and uses a provider network from imposing cost-sharing requirements for any benefit or service required under said subsection (a) that is delivered by an out-of-network provider.

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

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*January 1, 2021*	20-571
Sec. 3	*January 1, 2021*	20-616

Sec. 4	*from passage*	New section
Sec. 5	*January 1, 2021*	21a-254(j)
Sec. 6	*January 1, 2021*	21a-65(b)
Sec. 7	*January 1, 2021*	21a-70(a)
Sec. 8	*January 1, 2021*	21a-249(j)
Sec. 9	*January 1, 2021*	38a-492a
Sec. 10	*January 1, 2021*	38a-518a
Sec. 11	*January 1, 2021*	53a-13(b)(1)
Sec. 12	*January 1, 2021*	20-619(l)
Sec. 13	*January 1, 2022*	38a-492d
Sec. 14	*January 1, 2022*	38a-518d
Sec. 15	*October 1, 2020*	38a-493(f)
Sec. 16	*October 1, 2020*	38a-490a(b)
Sec. 17	*October 1, 2020*	38a-492k(b)(2)
Sec. 18	*October 1, 2020*	38a-492o(b)
Sec. 19	*October 1, 2020*	38a-492r(b)
Sec. 20	*October 1, 2020*	38a-492s(b)
Sec. 21	*October 1, 2020*	38a-492t(b)(3)
Sec. 22	*October 1, 2020*	38a-503(c)
Sec. 23	*October 1, 2020*	38a-503e(b)
Sec. 24	*October 1, 2020*	38a-503f(b)
Sec. 25	*October 1, 2020*	38a-511(c)
Sec. 26	*October 1, 2020*	38a-520(f)
Sec. 27	*October 1, 2020*	38a-516a(b)
Sec. 28	*October 1, 2020*	38a-518k(b)(2)
Sec. 29	*October 1, 2020*	38a-518o(b)
Sec. 30	*October 1, 2020*	38a-518r(b)
Sec. 31	*October 1, 2020*	38a-518s(b)
Sec. 32	*October 1, 2020*	38a-518t(b)(3)
Sec. 33	*October 1, 2020*	38a-530(c)
Sec. 34	*October 1, 2020*	38a-530e(b)
Sec. 35	*October 1, 2020*	38a-530f(b)
Sec. 36	*October 1, 2020*	38a-550(c)