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ResearchReport

Health Benefit Review Program: Acts Related to Health Benefit Mandates Effective on or After January 1, 2018

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Issue

For purposes of the health benefit review program, what acts related to health benefit mandates became effective on or after January 1, 2018?

Summary

The health benefit review program is a statutorily created program within the Insurance Department that requires the department, upon the Insurance and Real Estate Committee's request, to evaluate the social and financial impacts of mandated health benefits (CGS § 38a-21, as amended by PA 25-132, § 1).

This report summarizes the laws related to mandated health benefits that were effective on or after January 1, 2018.

(See OLR report 2025-R-0136 for a comprehensive list of all mandated health benefits for fully insured commercial health insurance policies and plans.)

Mandated Health Benefit

For purposes of the health benefit review program, a "mandated health benefit" is an existing statutory obligation of, or proposed legislation that would require, an insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society, or other entity

that offers individual or group health insurance or a medical or health care benefits plan in Connecticut to do the following:

1. allow an insured or enrollee to obtain health care treatment or services from a particular type of health care provider;

2. offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; or

3. offer or provide coverage for (a) a particular type of health care treatment or service or (b) medical equipment, medical supplies, or drugs used in connection with a health care treatment or service.

It includes any proposed legislation to expand or repeal an existing statutory obligation relating to health insurance coverage or medical benefits (CGS § 38a-21(a)(2)).

Public and Special Acts on Mandated Health Benefits

Table 1 below briefly summarizes the public acts related to health benefit mandates with an effective date on or after January 1, 2018. The table lists the acts in effective date order and includes the public act numbers along with the statutory citations where they were codified.

Table 1: Acts on Health Benefit Mandates Effective on or After January 1, 2018

Effective Date	Public Act Number (Statutory Citation)	Brief Description
January 1, 2018	PA 17-55 (CGS §§ 38a-509 & -536)	*Infertility Coverage* This act extends eligibility for infertility coverage under certain individual and group health insurance policies to people who are not healthy (prior eligibility was limited to those "presumably healthy") and allows them to receive coverage for the medically necessary costs of diagnosing and treating infertility.
January 1, 2018	PA 17-131, §§ 8 & 9 (CGS §§ 38a-492p & -518p)	*Substance Use Disorder Coverage* This act requires certain individual and group health insurance policies to cover, for insureds or enrollees who have been diagnosed with a substance use disorder, medically necessary (1) medically monitored inpatient detoxification services and (2) medically managed intensive inpatient detoxification services.
January 1, 2018	PA 17-228 (CGS §§ 38a-510(a) & -544(a))	*Step Therapy Prohibited for Metastatic Cancer Drugs* This act prohibits individual and group health insurance policies from requiring step therapy for cancer drugs prescribed to treat insureds diagnosed with stage IV metastatic cancer and in compliance with approved federal Food and Drug Administration (FDA) indications. Step therapy is a treatment approach that generally requires patients to try less expensive drugs before higher cost drugs.

Table 1 (continued)

Effective Date	Public Act Number (Statutory Citation)	Brief Description
January 1, 2018	PA 17-2, §§ 202 & 203, June Special Session (CGS §§ 38a-488a(b) & -514(b))	*Coverage for Mental or Nervous Conditions* This act repeals provisions requiring individual and group insurance policies to cover the following benefits: 1. evidence-based maternal, infant, and early childhood home visitation services designed to improve health outcomes for pregnant women, postpartum mothers, and newborns and children, including maternal substance use disorders or depression and relationship-focused interventions for children with mental or nervous conditions or substance use disorders; 2. intensive, family- and community-based treatment programs that focus on addressing environmental systems impacting chronic and violent juvenile offenders; 3. other home-based therapeutic interventions for children; 4. chemical maintenance treatment (i.e. when a person is admitted for the planned use of a substance under medical supervision); and 5. extended day treatment programs for children or youth with emotional disturbance, mental illness, behavior disorders, or multiple disabilities.
January 1, 2019	PA 18-10 (CGS §§ 38a-482c(a), -492q, -492r, -492s, -503e, -503f, -512c(a), -518q, -518r, -518s, -530e,& -530f)	*Essential Health Benefits and Preventive Health Services Coverage* This act requires individual and small employer group health insurance policies to cover 10 essential health benefits and prohibits the policies from including annual or lifetime limits on their dollar value. The benefits include ambulatory patient services, emergency services, hospitalization, maternity and newborn health care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services, immunization, and pediatric services. The act requires insurance policies to cover contraceptive drugs, devices, and products approved by the FDA, including a 12-month supply when prescribed by a licensed physician, physician assistant, or advanced practice registered nurse (APRN). The policy must do so without cost sharing (such as coinsurance, copayments, or deductibles) except when the provider is out-of-network. High deductible plans designed to be compatible with federally qualified health savings accounts must generally comply with the cost-sharing prohibition if permitted by federal law.

Table 1 (continued)

Effective Date	Public Act Number (Statutory Citation)	Brief Description
January 1, 2019	PA 18-43 (CGS §§ 5-259g & 38a-481(g)(2), -183(a), -208, -218)	***Pregnancy as a Qualifying Event for Special Enrollment Period*** This act requires certain health insurance plans to provide a special enrollment period to eligible pregnant women who do not have insurance that covers the Affordable Care Act's (ACA's) minimum essential health benefits or otherwise meets the minimum coverage requirements in state law. A special enrollment period is a time outside of open-enrollment when eligible individuals may apply for health insurance.
January 1, 2019	PA 18-69 (CGS §§ 38a-492t & -518t)	***Prosthetic Devices Coverage*** This act requires certain health insurance policies to cover prosthetic devices, and medically necessary repairs and replacements of them, subject to specified conditions. Coverage must be at least equivalent to the coverage Medicare provides for such devices, but a policy may limit coverage to a device that the patient's health care provider determines is most appropriate to meet his or her medical needs.
January 1, 2019	PA 18-159 (CGS §§ 38a-503 & -530)	***Coverage for Mammograms and Tomosynthesis*** This act expands coverage for mammograms and tomosynthesis under certain health insurance policies by defining "mammogram" as a mammographic examination or breast tomosynthesis, including any procedure with one of 13 specific Healthcare Common Procedure Coding System billing codes or any subsequent corresponding codes.
October 1, 2019	PA 19-98 (CGS §§ 38a-472a & -488a(d)-(h), -492e(b), -499, -503(d), -518e(b), -530(d))	***Certain Services by Advanced Practice Registered Nurses*** This act adds APRNs to various insurance statutes, generally requiring health insurers to cover mental health services provided by APRNs, including residential treatment, in the same manner as those provided by physicians. It also allows APRNs to (1) diagnose significant changes in a patient's diabetes symptoms for purposes of requiring insurers to cover medically necessary diabetes outpatient self-management training and education and (2) order neuropsychological testing of a child with cancer to assess cognitive or development delays due to treatment, for purposes of providing coverage under HUSKY without prior authorization.
January 1, 2020	PA 19-117, §§ 209 & 210 (CGS §§ 38a-503(b), (c) & -530(b), (c))	***Ultrasounds, Mammograms, and MRIs Coverage for Certain Women*** This act expands health insurance coverage for breast ultrasound screenings to include women whose physicians recommend it and who (1) are age 40 or older or (2) have a family history or prior personal history of breast cancer.

Table 1 (continued)

Effective Date	Public Act Number (Statutory Citation)	Brief Description
January 1, 2020	PA 19-117, § 246 (CGS § 38a-478r)	*Medical Necessity Coverage* This act requires certain health insurance policies to provide coverage for medically necessary health care services for emergency medical conditions.
January 1, 2020	PA 19-133 (CGS §§ 38a-490b & -516b)	*Hearing Aid Coverage* This act requires certain health insurance policies to cover hearing aids for any covered person, regardless of age, instead of only for children under age 13. Policies may limit coverage to one hearing aid per ear within a 24-month period.
January 1, 2020	PA 19-134 (CGS § 38a-476)	*Preexisting Conditions* This act prohibits short-term health insurance policies issued on a nonrenewable basis for a term of six months or less from containing a preexisting condition provision.
January 1, 2020	PA 19-159 (CGS §§ 38a-477ee, -488c, -488d, -514c, & -514d)	*Mental Health and Substance Use Disorder* This act prohibits certain health insurance policies from applying nonquantitative treatment limitations (such as preauthorization requirements) to mental health and substance use disorder benefits in a way that is substantially different from how they apply these limitations to medical and surgical benefits. It also generally prohibits health insurance policies from denying coverage for substance abuse services solely because they were provided under a court order.
July 31, 2020	PA 20-2, July Special Session (not codified)	*Telehealth Coverage* From July 31, 2020, to March 15, 2021, this act temporarily replaced the requirements and restrictions for health insurance coverage of telehealth services already in effect with similar but more expansive requirements. Among other things, this act prohibited (1) policies from excluding coverage for a telehealth platform that a telehealth provider selects and (2) a telehealth provider who receives reimbursement for providing a telehealth service from seeking any payment from the insured patient except for cost sharing. It required providers to accept the reimbursement amount as payment in full. The act also prohibited health carriers (e.g., insurers and Health Maintenance Organizations (HMOs)), until March 15, 2021, from reducing the amount of reimbursement they pay to telehealth providers for covered services appropriately provided through telehealth instead of in person.

Table 1 (continued)

Effective Date	Public Act Number (Statutory Citation)	Brief Description
May 10, 2021	PA 21-9 (not codified)	***Telehealth Coverage*** In response to the COVID-19 pandemic, the governor issued several executive orders in the spring of 2020 to modify the practice of telehealth to ensure residents had continued access to care. During the July 2020 Special Session, the legislature enacted PA 20-2, which temporarily codified several provisions of the governor's orders until March 15, 2021. This act (PA 21-9) extended these telehealth provisions until June 30, 2023. Among other things, the act continued to (1) expand the types of health professionals authorized to provide telehealth services, (2) expand allowable service delivery methods (such as telephone-only services), (3) establish requirements for telehealth providers seeking payment from underinsured and uninsured patients, and (4) expand requirements for insurance coverage of telehealth services.
July 1, 2021	PA 21-2, §§ 420 & 421, June Special Session (CGS §§ 38a-490a(a) & -516a(a))	***Coverage for Medically Necessary Early Intervention Services*** Expands to all eligible children under the birth-to-three program, insurance coverage under individual and group health insurance policies for medically necessary early intervention services provided as part of an individualized family service plan.
January 1, 2022	PA 20-4, §§ 13-14, July Special Session (CGS §§ 38a-492d & -518d)	***Coverage for Diabetes Screening, Testing, and Treatment*** This act requires certain individual and group health insurance policies to (1) expand coverage for screening, drugs, and devices for all types of diabetes; (2) limit out-of-pocket costs for covered diabetes-related drugs and devices; and (3) cover emergency diabetes-related drugs and devices prescribed and dispensed by a pharmacist once in a 12-month period in certain emergency situations (such as the patient informs the pharmacists that he or she has less than a week's supply of these diabetes-related drugs or devices).
January 1, 2022	PA 21-6, §§ 10 & 11 (CGS §§ 38a-492r(a) & -518r(a))	***Immunization Consultations*** This act requires certain health insurance policies to cover at least a 20-minute immunization consultation between a patient and a provider authorized to administer them (such as a physician or an APRN). Coverage is limited to consultations on immunizations recommended for the patient by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.
January 1, 2022	PA 21-57 (CGS § 38a-477hh)	***Pulse Oximeters*** This act prohibits certain insurers and others providing health insurance from denying coverage for an otherwise covered benefit if the denial is exclusively based on the insured's blood oxygen level as measured by a pulse oximeter.

Table 1 (continued)

Effective Date	Public Act Number (Statutory Citation)	Brief Description
January 1, 2022	PA 21-96 (CGS §§ 38a-1 & -477jj)	***Prescription Drug Formulary Changes*** This act generally prohibits certain health carriers from removing a covered prescription drug from a formulary (a list of covered drugs) or moving it to a higher cost sharing tier during a plan year. However, the act allows health carriers to (1) remove a prescription drug from a formulary with at least 90 days' advance notice if the FDA questions the drug's clinical safety or approves it for over-the-counter use and (2) move a drug to a higher cost-sharing tier if it is available in-network for $40 or less per month in any tier.
January 1, 2022	PA 21-125, §§ 1-3 (CGS §§ 38a-476b, -492u, & -518u)	***Psychotropic Drugs*** This act prohibits certain health insurers from requiring a health care provider to prescribe more outpatient psychotropic drugs than he or she deems clinically appropriate. The act similarly prevents any mental health care benefits provided under state law, with state funds, or to state employees, from requiring a provider to prescribe more of these drugs than he or she deems clinically appropriate. Lastly, for a less than 90-day supply of these drugs, the act generally prohibits insurers from imposing a cost-sharing amount (such as coinsurance, copayment, or deductible) that exceeds the cost sharing for a 90-day supply.
January 1, 2022	PA 21-149 (CGS §§ 38a-497 & -512b)	***Dental, Health, and Vision Insurance for Children to Age 26*** This act requires certain dental, health, and vision insurance policies to continue coverage for children, stepchildren, or other dependent children until the policy anniversary date on or after they turn age 26.
May 24, 2022	PA 22-81, §§ 35-37 (amending PA 21-9, §§ 3-5) (not codified)	***Telehealth Coverage*** This act extended PA 21-9's temporarily expanded insurance coverage requirements and prohibitions for telehealth services by one year to June 30, 2024; and specified that it does not apply if an insured's policy uses a provider network and he or she has audio-only telephone interactions with a telehealth provider that is out-of-network. It also specifies that the coverage requirements apply to high deductible health plans to the extent permitted by federal law.
July 1, 2022	PA 22-118, §§ 170 & 171 (CGS §§ 38a-497 & -512b)	***State Employee Dental Plan Dependents*** This act in practice made changes to fully insured dental plans the comptroller procures for state employees and certain nonstate public employees (such as municipal employees or employees of local boards of educations or public libraries). Under prior law, this coverage for employees' eligible children, stepchildren, and other dependent children had to be extended through the policy year after they turned age 26. Under this act, the coverage must instead continue until the end of the calendar year after the earlier of when the dependent (1) obtains coverage through their own employment or (2) turns age 26.

Table 1 (continued)

Effective Date	Public Act Number (Statutory Citation)	Brief Description
January 1, 2023	PA 22-47, §§ 41 & 42 (CGS §§ 38a-488e & -514e)	***Mental Health Wellness Exam Coverage*** This act requires certain fully insured health insurance plans to cover two mental health wellness examinations per year. The exams must be (1) conducted by a licensed mental health professional or primary care provider and (2) generally provided with no cost-sharing or prior authorization requirements.
January 1, 2023	PA 22-47, §§ 43 & 44 (CGS §§ 38a-488a(a), (b) & -514(a), (b))	***Coverage for Intensive Services for Mental or Nervous Conditions in Children and Adolescents*** This act requires certain fully insured health insurance plans to cover intensive services for treating a child's mental or nervous condition that are evidence-based, in addition to ones that are home-based as the law already required. It also expands this coverage requirement to include services designed for adolescents, rather than those only for children.
January 1, 2023	PA 22-47, §§ 47 & 48 (CGS §§ 38a-488f & -514f)	***Services Provided Under a Collaborative Care Model*** This act requires certain fully insured health insurance policies to cover services that are provided under a Collaborative Care Model (i.e. the integrated delivery of behavioral health and primary care services by a primary care team). This coverage must include specified Current Procedural Terminology and Healthcare Common Procedure Coding System codes that relate to, among other things, collaborative care management.
January 1, 2023	PA 22-47, §§ 49-54 (CGS §§ 38a-193(c)(3), -472f(c)(1), -488a(h), -514(h))	***Children's Access to Urgent Crisis Centers*** This act generally decreased health insurance barriers to accessing services at Department of Children and Families (DCF) licensed urgent crisis centers (centers dedicated to treating children's urgent mental or behavioral health needs). Specifically, by prohibiting health carriers from (1) requiring prior authorization for urgent crisis center services or (2) imposing a cost-sharing level for out-of-network services provided at these urgent crisis centers that is greater than the in-network level. It generally prohibited balance billing for covered services at out-of-network urgent crisis centers, established maximum billable amounts, and required health carriers to provide people with access to these centers to the extent they are available.

Table 1 (continued)

Effective Date	Public Act Number (Statutory Citation)	Brief Description
January 1, 2023	PA 22-47, §§ 55 & 56 (CGS §§ 38a-488g & -514g)	***Prior Authorization Prohibited for Certain Emergency Acute Inpatient Psychiatric Services*** This act generally prohibits health carriers from requiring prior authorization for acute inpatient psychiatric services if they are provided (1) after a hospital emergency department admission; (2) under a referral from the insured's treating physician, psychologist, or APRN if the insured poses an imminent danger to himself or others; or (3) at a DCF-licensed urgent crisis center. It also requires certain health care providers delivering acute inpatient psychiatric services, or referring someone for these services, to provide an insured with a written notice warning them of the potential costs. The notice must state that the insured may (1) incur out-of-pocket costs if the services are not covered by his or her health insurance and (2) choose to wait for an in-network bed for the services or risk incurring out-of-network costs.
January 1, 2023	PA 22-90 (CGS §§ 38a-503, -503g, -530, & -530g)	***Breast and Ovarian Cancer*** This act expanded fully insured commercial health insurance coverage requirements for mammograms, ultrasounds, MRI, breast biopsies, certain prophylactic mastectomies, and breast reconstruction surgery, subject to certain conditions. Among other things, the act requires these policies to also cover BRCA1 and BRCA2 genetic testing and routine ovarian cancer screenings for certain people. The act generally requires these services be provided at no out-of-pocket cost.
June 26, 2023	PA 23-148 (CGS §§ 38a-488e & -514e)	***Coverage for Mental Health Wellness Examinations*** This act eliminates the requirement that certain commercial health insurance policies cover mental health wellness examinations when performed by a primary care provider but maintains the existing requirement that the policies cover the examinations when performed by a licensed mental health professional.
October 1, 2023	PA 23-127, §§ 11 & 12 (CGS §§ 38a-509 & -536)	***Coverage for Infertility Diagnosis and Treatment*** This act prohibits certain health insurance policies, beginning January 1, 2024, from discriminating on the basis of gender identity or expression, sexual orientation, or age with respect to coverage for medically necessary infertility diagnosis and treatment. It also revises the allowed parameters for coverage of infertility-related expenses to conform to the federal ACA. Specifically, it eliminates the ability of a policy to (1) limit infertility coverage to those (a) under age 40 and (b) who had coverage under the policy for at least 12 months and (2) require an insured to disclose any previous infertility treatment covered under a different policy.

Table 1 (continued)

Effective Date	Public Act Number (Statutory Citation)	Brief Description
January 1, 2024	PA 23-174, §§ 3 & 4 (CGS §§ 38a-492v & -518v)	*Coverage for In-Home Hospice Services* This act requires certain individual and group health insurance policies to cover in-home hospice services provided by a licensed hospice home care agency to the same extent they cover hospital in-patient hospice services and subject to the same terms and conditions that apply to all other benefits under the policy. It also prohibits policies from excluding coverage for a hospice service solely because it is provided in the home and not at a hospital, as long as the home service is appropriate for the insured. Under the act, health insurers, HMOs, and other entities may still conduct utilization review for in-home hospice services, as long as it is done in the same manner, and uses the same clinical criteria, as for the same hospice services provided in a hospital.
January 1, 2024	PA 23-204, §§ 225-227 (CGS §§ 38a-510(a) & -544(a))	*Step Therapy* This act lowers, from 60 to 30 days, the maximum amount of time an insurer can require an insured to use step therapy. For the three-year period beginning January 1, 2024, it also prohibits step therapy for drugs used to treat schizophrenia, major depressive disorder, or bipolar disorder. Additionally, a health care provider treating an insured with these conditions may deem step therapy clinically ineffective, generally requiring insurers to authorize dispensation of and coverage for the drug prescribed by the provider, if it is covered under the insurance policy or contract.

Table 1 (continued)

Effective Date	Public Act Number (Statutory Citation)	Brief Description
Most provisions effective June 4, 2024	PA 24-110 (CGS §§ 19a-906, 21a -249(c)(5), & 38a-477mm, -499a(a), -526a(a) (various provisions of PA 21-9 repealed)	***Telehealth*** This act makes permanent certain temporarily expanded requirements for telehealth service delivery and insurance coverage that were scheduled to sunset on June 30, 2024. For example, the act (1) allows authorized telehealth providers to give services using audio-only telephones and, subject to applicable state and federal requirements, from any location to patients at any location and (2) prohibits health carriers from reducing their reimbursement amounts for covered services appropriately provided through telehealth. Among other changes, the act expands the list of authorized telehealth providers to include all Connecticut licensed health care providers and pharmacists. But it also specifies that existing laws on health insurance coverage of telehealth services remain applicable only to certain licensed health care providers. The act also repeals a provision in prior law that permanently allowed out-of-state mental or behavioral health services providers to practice telehealth in Connecticut under certain conditions. It instead temporarily allows them to do so, until June 30, 2025, if they meet certain requirements, such as registering with the Department of Public Health and obtaining a Connecticut license within a specified timeframe.
July 1, 2024	PA 22-81, §§ 39-40 (CGS §§ 38a-499a & -526a)	***Telehealth*** This act requires insurance policies to cover services provided through telehealth to the same extent that they cover them when provided in person by a Connecticut-licensed provider, rather than by any provider as under prior law.
July 1, 2024	PA 24-58 (CGS §§ 17b-278i, 38a-492w, -518w & 42-337, et seq.)	***Wheelchair Repair*** This act, among other things, (1) sets timeliness and reporting requirements related to wheelchair repair and (2) restricts prior authorization and new prescription requirements for certain wheelchair repairs under Medicaid and private health insurance.
October 1, 2024	PA 24-138, § 11 (CGS § 38a-564(4))	***Small Employer Definition*** Beginning January 1, 2025, this act conforms the statutory definition of "small employer" in the health insurance laws to what has been existing insurance department practice since at least 2015. Specifically, the act defines it as an employer with an average of at least one and no more than 50 employees on business days in the prior calendar year and at least one employee on the first day of the group health insurance plan year.

Table 1 (continued)

Effective Date	Public Act Number (Statutory Citation)	Brief Description
January 1, 2025	PA 24-19, §§ 18 & 19 (CGS §§ 38a-492x & -518x)	***Coronary Calcium Scans*** This act requires certain fully insured individual and group health insurance policies to cover coronary calcium scans. Under the act, these are CT scans of the heart looking for calcium deposits in arteries.
January 1, 2025	PA 24-19, §§ 34-35 (CGS §§ 38a-498a & -525a)	***Ambulance Services' Prior Authorization Prohibited*** This act prohibits certain health insurance policies from having an enrollee get approval from the health carrier before being transported to a hospital by ambulance when medically necessary. The act also prohibits a health carrier from denying payment to an ambulance provider responding to a 9-1-1 call because the enrollee did not get a prior authorization for the call or the ambulance transport to a hospital.
January 1, 2025	PA 24-81, §§ 101-104 (CGS §§ 38a-511(c), -511a, -550(c), -550a)	***Copayment-Only Health Plans*** This act exempts copayment-only health plans from existing copayment limitations for in-network (1) MRIs and CAT or PET scans and (2) physical and occupational therapy services. Under the act, a "copayment-only health plan" is a health plan that (1) imposes a specific dollar amount that the insured pays for a covered health care service or prescription drug and (2) does not include deductibles or coinsurance.
July 8, 2025	PA 25-132, §§ 3 & 4 (not yet codified)	***Wheelchair Repairs*** This act allows, rather than requires as under prior law, the insurance commissioner to adopt regulations to implement health insurance requirements for medically necessary wheelchair repairs and replacements. By law, an insurer cannot require a new prescription or prior authorization for the medically necessary repair or replacement of a complex rehabilitation technology wheelchair unless the original prescription is older than five years.
January 1, 2026	PA 25-16, §§ 4 & 5 (not yet codified)	***Biomarker Testing Coverage*** This act generally requires individual and group health insurance policies to cover biomarker testing to diagnose and treat patient diseases, such as cancer. The use of testing must be supported by medical and scientific evidence. Generally, biomarker testing identifies certain gene mutations, proteins, or other molecules that help health care providers diagnose diseases and choose targeted treatments that may help improve patient outcomes.
January 1, 2026	PA 25-94, §§ 4 & 5 (not yet codified)	***Step Therapy Restrictions*** This act limits a health carrier's use of step therapy. The act prohibits certain health insurance policies or contracts from requiring the use of step therapy for drugs used to treat multiple sclerosis or rheumatoid arthritis, as long as the drug complies with approved FDA indications. Additionally, the act makes permanent a prohibition on the use of step therapy for drugs used to treat schizophrenia, major depressive disorder, or bipolar disorder.

Table 1 (continued)

Effective Date	Public Act Number (Statutory Citation)	Brief Description
January 1, 2026	PA 25-94, §§ 8 & 9 (not yet codified)	***General Anesthesia Reimbursement*** This act prohibits certain individual and group health insurance policies that cover general anesthesia from (1) imposing arbitrary time limits on reimbursement for general anesthesia during a medically necessary procedure or (2) denying, reducing, terminating, or failing to provide reimbursement for general anesthesia solely because its duration exceeded the insurer's predetermined time limit for the care.
July 1, 2026	PA 25-167, § 8 (not yet codified)	***In-Network Liability for Out-of-Pocket Prescription Drug Expenses*** This act generally requires health carriers to credit insureds or enrollees for certain prescription drug costs when determining in-network liability for out-of-pocket expenses (such as coinsurance, copayment, or deductible) paid directly to a pharmacy or health care provider for prescription drugs. It requires health carriers to develop a proof of payment form and publish it on their website that insureds or enrollees must provide to receive the credit for out-of-network purchases. It also limits the total amount credited toward any insured's or enrollee's annual out-of-pocket expense for prescription drugs purchased from an out-of-network health care provider. It prohibits carrying over a credit to a new policy period.

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