
OLR Bill Analysis

HB 5482

AN ACT CONCERNING TWELVE-MONTH COVERAGE FOR CONTRACEPTION AND HORMONE THERAPY.

SUMMARY

This bill sets requirements related to prescription hormone therapy coverage in private insurance and Medicaid. Prescription hormone therapy includes all federal Food and Drug Administration (FDA)-approved drugs (excluding GLP-1 drugs) used to medically suppress, increase, or replace hormones that the body is not producing at intended levels, as determined by the provider. It requires private health insurers that cover the therapy to reimburse for a 12-month supply and any administration-related supplies dispensed at one time, with certain exceptions.

With certain exceptions, the bill also requires the Department of Social Services (DSS) commissioner to provide Medicaid coverage for a (1) medically necessary 12-month supply of prescription hormone therapy and any administration-related supplies and (2) 12-month supply of any FDA-approved prescription contraception drug, device, or product.

EFFECTIVE DATE: January 1, 2027

PRIVATE INSURANCE COVERAGE

The bill requires individual and group health insurance companies to reimburse for a 12-month supply and any necessary administration supplies of a covered prescription hormone therapy dispensed at one time, unless the:

1. insured requests a smaller supply;
2. prescribing provider instructs that the insured must receive a smaller supply; or

3. prescription hormone therapy is a controlled substance, in which case the health plan must reimburse for the maximum refills allowed for the insured under state and federal law.

The requirement applies to each individual or group health insurer, health care center (HMO), fraternal benefit society, health service corporation, medical service corporation, or other entity that delivers, issues, renews, amends, or continues a health insurance policy in the state on or after January 1, 2027, that covers (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, or (4) hospital or medical services. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

The bill specifies that it does not prohibit a health plan from limiting refills in the last quarter of the plan year if a 12-month supply has already been dispensed in the plan year. To the extent state and federal law allows, the bill allows plans to apply drug utilization strategies to prescription hormone therapies.

MEDICAID COVERAGE

Prescription Hormone Therapy

The bill requires the DSS commissioner, to the extent federal law allows, to provide Medicaid coverage for a medically necessary (see BACKGROUND) 12-month supply of prescription hormone therapy and any necessary supplies to administer it dispensed at one time, unless the:

1. insured requests a smaller supply;
2. prescribing provider instructs that the insured must receive a smaller supply; or
3. prescription hormone therapy is a controlled substance, in which case DSS must reimburse for the maximum refills allowed for the insured under state and federal law.

Contraception

The bill requires the DSS commissioner, to the extent federal law allows, to provide Medicaid coverage for a 12-month supply of any prescribed FDA-approved contraception drug, device, or product dispensed at one time, unless the Medicaid enrollee or the enrollee's prescribing health care provider requests a smaller supply.

BACKGROUND

Medically Necessary Services in Medicaid

Under the state's Medicaid program, medically necessary services are those health services required to prevent, identify, diagnose, treat, rehabilitate, or ameliorate a person's medical condition, including mental illness or its effects, to attain or maintain the person's achievable health and independent functioning (CGS § 17b-259b). Medically necessary services must also be:

1. consistent with generally accepted medical practice standards;
2. clinically appropriate in terms of type, frequency, timing, site, extent, and duration and considered effective for the person's illness, injury, or disease;
3. not primarily for the person's or provider's convenience;
4. not more costly than an alternative service likely to produce equivalent therapeutic or diagnostic results; and
5. based on an assessment of the person and his or her medical condition.

COMMITTEE ACTION

Human Services Committee

Joint Favorable

Yea 16 Nay 7 (03/19/2026)