

# Background

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## Introduction

The Legislative Program Review and Investigations Committee voted to conduct a study in April 2005 of Mental Health Parity: Insurance Coverage and Utilization. The review focuses on the implementation of Public Act 99-284 that requires health plan coverage for diagnosis and treatment of mental conditions place no greater financial burden on an insured individual than for physical conditions under the same policy. The law applies only to individual and employer-based fully insured health plans. The parity requirement does not apply to public health insurance programs -- e.g., Medicaid, the medical portion of State Administered General Assistance administered by the Department of Social Services, or Medicare -- or self-funded health care plans covered under the federal Employee Retirement Income Security Act (ERISA)<sup>1</sup>.

**Background.** In Connecticut a limited mental health parity law was enacted in 1997, requiring parity only for certain biologically based mental illnesses. A more comprehensive parity law was adopted in 1999 and required health insurers to implement the provisions of the law beginning January 1, 2000. Because the law only applies to fully insured health plans, it affects less than one-third of Connecticut residents.<sup>2</sup> Unless specifically noted, this report focuses only on enrollees of those policies covered by the law. The Connecticut Insurance Department (CID) is the state agency charged with enforcement authority, because this agency is responsible for the regulation of health insurers and the products offered by them.

Prior to the adoption of parity laws in Connecticut and elsewhere, health plans placed limits on the scope of mental health services through differing co-pays for mental versus physical conditions, limiting the number of annual mental health visits, and imposing differing annual and lifetime monetary caps for physical conditions. States began adopting mental health parity laws during the 1990s. The objective of these laws were threefold:

- making mental health and substance abuse benefits equal to physical health benefits within a health plan (private health insurance plans typically provided lower levels of coverage for the treatment of mental illness than for the treatment of other illnesses);
- reducing the financial burden for consumers of mental health services and their families by prohibiting higher co-pays and limits on benefits than those in place for medical services; and

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<sup>1</sup> The state insurance department does not have jurisdiction over most self-insured health plans, which fall under the Employee Retirement Income Security Act (ERISA). ERISA is a federal law that is enforced by the U.S. Department of Labor, Employee Benefits Security Administration (DOL-EBSA). If a member of a self-insured health plan needs assistance, he or she would contact the DOL-EBSA. Self-funded government plans and church plans do not fall under ERISA but are not required to provide state mandates because they are self-funded.

<sup>2</sup> According to information submitted to CID as of December 2003, about 1.1 million individuals are enrolled in self-funded plans. There are slightly less than 1 million individuals enrolled in public programs (i.e., Medicare, Medicaid, and SAGA).

- reducing the stigma associated with these services by recognizing that benefits should be equal.

**Study limitations.** There are serious limitations in conducting a thorough evaluation of the mental health parity law in Connecticut. First, the law itself is limited in scope – applying only to private fully insured health plans, as will be discussed in the report, the plan covers an ever-decreasing percentage of the state’s population. Second, there are a wide variety of health care plans that offer a mixture of benefit structures that apply to both medical and mental health conditions. Evaluating parity with so many variations of plan offerings is problematic. Third, the only official state regulatory agency for mental health parity is CID, and the activities conducted by it in specifically measuring mental health parity are somewhat limited, as will be discussed in this report.

Because the state’s role is limited, information and publicly maintained data are also incomplete. Mental health parity is a legal requirement, not a specific program that a state agency operates, so very little detailed information is collected at the state level on how the parity law affects mental health care utilization and costs in the private sector. In this briefing report, committee staff analyze data submitted to CID by utilization review companies annually on the numbers of utilization review requests<sup>3</sup> performed for mental health treatment, denials of treatment, and appeals of those decisions filed by enrollees. Information on the numbers and types of complaints filed by consumers with CID and other state agencies concerning mental health benefits and coverage is also presented.

Committee staff have conducted interviews with health insurance representatives, mental health and substance abuse advocates, and practitioners. Most of those interviewed expressed a general belief that the parity law has had a positive impact on the provision of services. However, practitioners noted three areas that are of concern to them including:

- low provider reimbursement rates for mental health treatment;
- disruptive and time-consuming utilization reviews to determine medical necessity and appropriateness of treatment; and
- limited behavioral health provider networks which may result in inadequate access to care.

During the next phase of this study, program review committee staff will be conducting a survey of mental health providers to further identify their concerns, as well as solicit their opinions regarding the impact of the parity law on service provision, availability, and accessibility.

Because of the lack of data collected at the state agency level, committee staff cannot measure the impact of the mental health parity law without the cooperation of licensed health

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<sup>3</sup> Utilization review is the prospective or concurrent assessment of the necessity and appropriateness of treatment or care given or proposed to be given to an insured person. A particular treatment strategy may be denied or restricted on the grounds that it is not “medically necessary” or “medically appropriate.” These terms are not defined by state law or regulation.

insurers offering fully insured health plans in the state. The committee staff have submitted an extensive request for mental health care utilization and cost information to health insurers and are working with their representatives to obtain these data. These data should allow the committee to evaluate utilization and cost trends since prior to passage of the parity law. Program review staff anticipate analysis of these data to be included in the next phase of this study.

The briefing report contains four sections. The first section gives an overview of the history of mandated mental health benefits in Connecticut and summarizes the 1999 parity law. A brief discussion of the limited federal Mental Health Parity Law is also included in this section. Section Two provides an overview of the participants in the private insurance market, including the number of health insurers offering fully insured health plans and the number of mental health providers licensed by the Department of Public Health (DPH). Section Three describes the regulatory activities of CID in ensuring insurers comply with the parity law, analyzes utilization review statistics that are reported to the insurance department by managed care organizations, and evaluates consumer mental health complaints. Section Four describes two other state offices that handle health care complaints – the Office of the Attorney General and the Office of the Managed Care Ombudsman -- and contains an analysis of those involving mental health.



# Section One

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## Mental Health Parity

Before the adoption of Connecticut's parity law, mental health benefits required under state law were limited. Prior to 1997, state law required group insurance policies, at a minimum, to provide:

- 60 days of inpatient mental health care annually;
- up to 120 days of outpatient care; and
- annual benefits of \$2,000 per year for major medical policies.

Individual health care policies were not required to provide any state mandated mental health benefits.

As mental health advocates began drawing attention to the discrepancies in treatment coverage between mental health and physical health insurance, states began to require that mental health and/or substance abuse treatment be covered in the same way as other medical care. It is important to note, mental health parity laws do not guarantee unlimited benefits, but only require equivalent coverage to that provided for physical disorders within a specific plan. Therefore, it is still possible for an individual to exhaust his or her entire mental health coverage because many insurance policies have aggregate monetary ceilings for all types of benefits. Thus, individuals who reach these benefit ceilings would need to forego care or pay out-of-pocket for continued treatment because coverage would have expired.

**Federal Mental Health Parity Act.** At the federal level, the Mental Health Parity Act (Public Law 104-204) was adopted in 1996 and became effective January 1, 1998. The law applies to employers with 50 or more employees, including self-insured companies. It requires that any lifetime and annual reimbursement cap for mental health services be equal to that for physical health services. However, the law *does not require* mental health coverage to be provided in health insurance plans, nor does it prohibit employers from eliminating mental health benefits. Under the act, mental health benefits do not include substance abuse or chemical dependency.

To help soften any dramatic cost increases to employers, the act exempts plans that incur a premium increase of one percent or more. Companies seeking an exemption from the law must show proof of the one percent or greater premium increase based on real data from actual claims and administrative cost for six months. Federal rules require all employers and insurance companies affected by the law to comply with its requirements for at least six months before applying for an exemption.

While the policy objective is to achieve mental health parity in coverage, the federal law does not change or prohibit certain insurance practices such as:

- setting separate co-pays and deductibles for mental health services; or

- limiting or denying mental health services to enrollees whose needs are not defined as "medical necessary. "

The act contained a sunset provision originally set for September 30, 2001, but has been extended to December 31, 2005.

**Other states.** States began enacting parity laws in the 1990s, and to date more than 33 states have passed mental health parity laws. However, there is considerable variation in the scope of the laws enacted by individual states. Some states mirror the federal mandate, others limit the insurance coverage to a specific list of biologically based mental illnesses, and still others, like Connecticut, provide for broad coverage of almost all mental illnesses, including alcohol and substance abuse. Appendix A provides a comprehensive list of states with mental health parity laws and describes the scope of each state's law.

### **Connecticut's Mental Health Parity Laws**

The Connecticut General Assembly initially enacted a parity law in 1997, which applied only to certain biologically based illnesses, and then broadened the law in 1999. This section provides a summary of Connecticut's mandates for mental health insurance coverage.

**Biologically based parity laws (P.A. 97-99 and P.A. 97-8, June Special Session).** The legislature adopted two separate acts in 1997 – one requiring mental health parity in group health insurance policies; the other in individual health insurance policies. Public Act 97-99, as part of a broader bill regulating managed care, required mental health parity for coverage of biologically based mental or nervous conditions in fully insured group health insurance contracts that is at least equal to the coverage provided for medical or surgical conditions. The law originally required parity in fully insured group health policies with respect to eight conditions including: (1) schizoaffective disorder; (2) major depressive disorder; (3) bipolar disorder; (4) paranoia; (5) other psychotic disorder; (6) obsessive-compulsive disorder; (7) panic disorder; and (8) pervasive developmental disorder or autism. A ninth condition, schizophrenia, was added under P.A. 97-8, June Special Session (JSS).

If covered medical or surgical conditions in a policy were subject to a copayment, deductible, coinsurance, or lifetime benefit maximum, biologically based mental or nervous conditions would also be subject to the same requirements. Furthermore, the law did not affect coverage for other types of mental illnesses -- which under existing state law only applied to group health policies -- still subject to existing state-mandated limitations. The act allowed health insurers to perform utilization review to determine "medical necessity" for treatment for biologically based mental or nervous conditions if, under the plan, medical or surgical conditions had to satisfy this requirement.

P.A. 97-8, (JSS) extended the parity requirement to health insurers offering individual policies and the covered conditions were the same as those for group health insurance. It revised the definition of "biologically based mental illness" by specifying that the eligible mental disorders were those defined in the most recent edition of the American Psychiatric

Association's Diagnosis and Statistical Manual of Mental Disorders (DSM), the manual used for diagnosing mental illness.

**Expansion of mental health parity (P.A. 99-284).** By 1999, pressure to enact a more comprehensive mental health parity law resulted in the adoption of Public Act 99-284. The act expanded the requirement for mental health parity in fully insured group *and* individual health insurance contracts by eliminating the biologically based criteria and instead applying parity to all mental health conditions as defined by the DSM. Thus, parity is required for all mental or nervous conditions by prohibiting health policies that contain terms, conditions, or benefits that place a greater financial burden on an insured for care of mental health conditions than for care of medical, surgical or physical conditions.

*Conditions covered and excluded.* The act applies to mental disorders defined in DSM-IV, which was published in 1994 and is the most recent edition of the Diagnostic and Statistical Manual of Mental Disorder. While mental health conditions as defined in the DSM are covered, the act specifically excludes the following from coverage:

- mental retardation;
- learning, motor skills, communication, and caffeine-related disorders;
- relational problems; and
- other conditions that may be the focus of clinical attention that are not otherwise defined as mental disorders in the manual.

*Inpatient coverage.* In addition to specifying the covered conditions, the act eliminates the limitations on inpatient care for the treatment of substance abuse in group health insurance policies (previously a 45-day limit). The act also requires parity for the treatment of substance abuse in individual and group plans because it is a mental disorder under the DSM.

*Policies affected.* The parity requirements apply to individual and group health insurance policies offered in Connecticut beginning January 1, 2000. The implementation requirement affects policies offered by HMOs, managed care organizations, and indemnity insurers that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, and (4) hospital or medical services.<sup>4</sup> The act also requires the HUSKY Plan, Part B – a publicly funded health plan that covers uninsured children who are poor but not eligible for Medicaid -- to comply with the provisions of the act.

*Provider reimbursement.* The act mandates individual insurance policies provide insurance reimbursement to certain allied health care providers' authority to diagnose and treat mental or nervous conditions, which already exists under group policies. This includes:

- licensed clinical psychologists;
- licensed clinical social workers;
- social workers certified as independent before October 1, 1990;

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<sup>4</sup> Disability income, accident-only, long-term care, hospital confinement, specified accident, medicare supplement, limited benefit coverage, and specified disease policies are not covered under the act.

- licensed marital and family therapists or those certified before October 1, 1992; and
- licensed or certified alcohol and drug counselors (extended to both group and individual policies in this act).

People with master's degrees in social work or marital family therapy may receive insurance reimbursement when their services are provided in a child guidance clinic or a residential treatment facility under the supervision of a psychiatrist, psychologist, physician, or licensed social worker or marital and family therapist who is also eligible for reimbursement.

Private insurance reimbursement is also required for outpatient services rendered in: (1) a nonprofit community mental health center as defined by the Department of Mental Health and Addiction Services; (2) a licensed nonprofit adult psychiatric clinic operated by an accredited hospital; or (3) a residential treatment facility. Services in these facilities must be provided under the supervision of a: psychiatrist; licensed psychologist; licensed marital and family therapist; or a licensed clinical social worker who is eligible for reimbursement. Services must also be within the scope of the license issued to the center or clinic by the Department of Public Health.

*Utilization review.* Although the law *prohibits* health care plans from imposing more restrictive limits on coverage for mental disorders, it is important to note that health plans may still subject all types of care (mental, medical, surgical, and physical) to utilization review. Thus, while a plan may not impose discriminatory limits on the care of mental disorders in its policies, it may make judgments about the level or extent of any given recommended treatment that will be covered under the plan. Judgments about a particular treatment strategy may be denied or restricted on the grounds that it is not “medically necessary” or “medically appropriate.” State law requires both an internal and external appeal process be available to enrollees who are denied services, which are discussed in Section Three.

## Section Two

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### **A Profile of Mental Health Services: Consumers, Providers, and Insurers**

**Prevalence of mental illness in U.S.** Mental illness is the term that refers collectively to all diagnosable mental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). A mental disorder is characterized by alterations in thinking, mood, or behavior that contribute to individual and family distress, impaired functioning, loss of freedom, and heightened risk of pain, disability, or death. The degree of mental illness is distinguished by differences in symptoms, duration, severity, and prognosis depending on the specific diagnosis.<sup>5</sup>

The diagnosis of mental disorders is more difficult than diagnosis of general medical disorders, since there is no apparent injury or lab test that can identify the illness. The diagnosis of mental disorders must instead rely on patients' reports of the intensity and duration of symptoms; signs from their mental status examination; and clinician observation of their behavior including functional impairment. These clues are grouped together by the clinician into recognizable patterns known as syndromes. When the syndrome meets all the criteria for a specific diagnosis, it constitutes a mental disorder.<sup>6</sup>

Mental disorders are common in the United States. An estimated 22.1 percent of Americans ages 18 and older—about 1 in 5 adults—suffer from a diagnosable mental disorder in a given year.<sup>7</sup> In Connecticut, according to a 2005 report published by the Lieutenant Governor's Mental Health Cabinet, there are nearly 600,000 Connecticut adults who have symptoms of mental illness. Of these, about 135,000 have a serious mental illness and another 66,000 suffer from severe and persistent mental illness. Although no definite numbers exist for the number of Connecticut children with mental illness, estimates range from 87,500 to 125,000 children and youth who also exhibit a mental health condition.

#### **Mental Health Providers**

There are several different types of mental health providers who practice in a variety of settings, including inpatient acute-care and psychiatric hospitals, partial hospitalization and day treatment programs, outpatient clinics, and community private practices. There are a number of elements to treatment including psychotherapy, pharmacological therapy, and peer-to-peer support.

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<sup>5</sup>Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*, Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

<sup>6</sup> Ibid.

<sup>7</sup> Regier DA, Narrow WE, Rae DS, et al. The de facto mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, 1993; 50(2): 85-94.

Based on 2005 data, there are over 10,000 mental health providers licensed or certified by the Department of Public Health in Connecticut (the department only collects information on the who is licensed, which may differ from who is actively practicing). Table II-1 shows clinical social workers are by far the largest group of mental health providers in the state, accounting for 44 percent of all mental health providers in 2005. Of the provider categories depicted in the table, only psychiatrists can legally prescribe medications. However, many individuals also receive mental health care services, particularly in the form of pharmacological therapy, from their primary care physicians, and never visit a mental health provider. Thus, the numbers of practitioners providing treatment for mental health conditions are most likely underrepresented by the numbers in the table.

**Table II-1. Licensed and Certified Mental Health Providers in CT.**

Type	1997	1998	1999	2000	2001	2002	2003	2004	2005
Physicians identifying psychiatry as specialty	n/a	n/a	n/a	n/a	n/a	1,426	1,467	1,466	1,460
Clinical Psychologists	1,371	1,396	1,437	1,463	1,472	1,448	1,550	1,597	1,611
Clinical Social Workers	3,502	3,605	3,738	3,874	3,912	3,924	4,263	4,408	4,463
Prof. Counselors <sup>1</sup>	--	369	1,084	1,311	1,310	1,303	1,226	1,254	1,138
Marital & Family Therapists	536	607	638	817	815	785	717	708	675
Licensed Alcohol & Drug Counselors <sup>2</sup>	--	--	524	545	549	542	575	585	593
Certified Alcohol & Drug Counselors <sup>3</sup>	--	--	352	303	279	255	260	248	251
Total	--	--	--	--	--	9,683	10,058	10,266	10,191
n/a – not available <sup>1</sup> Licensure program began in 1998 <sup>2</sup> Licensure program began in 1999 <sup>3</sup> Certification program began in 1999 Source: DPH.									

## Health Insurers

There are 27 managed care organizations licensed to operate in the state that are required to comply with the mental health parity law - six Health Maintenance Organizations (HMOs) and 21 managed care indemnity insurers.<sup>8</sup> In total, these companies accounted for written premiums of \$4.3 billion dollars in 2003 for fully insured plans issued in Connecticut.

HMOs and other health insurers may offer individual and/or group health policies. As noted in Section One, the mental health parity law applies only to fully insured specific health policies -- basic hospital expense, basic medical-surgical expense, major medical, hospital or medical service plan contracts, and hospital and medical coverage provided to subscribers of a health center. The insurance department does not track the number of policies offered within each of these broad categories.

<sup>8</sup> There are also 11 indemnity companies that write only student insurance policies and those policies would be subject to state mandates.

According to CID, almost all of the health policies offered in Connecticut, whether through an HMO or a managed care indemnity insurer, include a network of providers and a utilization review component. An employer may offer a range of plans and let its employees choose among them, or select a specific plan. As an example, the State of Connecticut offers its employees a choice between three different health insurers each of whom offers three types of health plans:

- point of service plan (POS) - health care services are available both within and outside a defined network of providers; no referrals are necessary to receive care from participating providers; health care services obtained outside the defined network may require pre-authorization and are reimbursed at the rate of 80% of the plan's allowable cost after the annual deductible has been met;
- point of enrollment plan (POE) - health care services are covered only from a defined network of providers; no referrals are necessary to receive care from participating providers; health care services obtained outside the defined network may not be covered; or
- point of enrollment gatekeeper plan (POE-G) - health care services are available only from a defined network of providers; a primary care physician (PCP) must be chosen to coordinate all care; referrals are required from the PCP for all specialist services.

Depending on the plan selected by an employee, he or she may be required to contribute different amounts to cover the difference in premiums. Also, there may be different deductibles, coinsurance requirements, and co-pays depending on the plan selected and whether out-of-network providers are being used. This example illustrates that, in terms of mental health parity, even when health benefits are compared among state employees, there could be differences in benefit levels in terms of what employees pay (in premiums and co-pays) because of the plan selected and how services are accessed. (See Appendix B for more detail.)

**Enrollment trends.** Managed care organizations must submit certain statistics to CID annually, including enrollment statistics. Table II-2 shows the overall number of enrollees in managed care fully insured and self-insured plans since 1997. The reason that there is a 41 percent growth rate between 1997 and 2003 according to insurance department staff is because indemnity insurers are not required to report enrollment figures and some managed care organizations may not have understood the initial reporting requirements. Given these data limitations, most of the enrollee growth can be attributed to the increase in the number of individuals enrolled in self-insured health plans, which almost doubled since 1997. There was only a 17 percent increase in enrollment in fully insured plans over the same time period.

<i>Plan Type</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>
Fully-Insured	1.1	1.1	1.4	1.5	1.5	1.4	1.3
Self-funded	.6	.6	.6	1.0	.9	1.1	1.1
Total	1.7	1.7	2.0	1.5	2.4	2.5	2.4
Source of Data: CID Consumer Report Cards 1997 – 2003.							

Self insured health plans have gained in popularity among large employers and labor unions. These groups create a pool of money from employers and employee contributions and then pay for the health care services of their members from this fund. Typically, self-insured plans will hire a third party administrator (TPA) to handle all administrative tasks including processing claims, ensuring payments are made, and conducting utilization review for medical necessity. Often employers contract with health insurers to act as a TPA for all health care claims.

One possible reason for the increase in the number of enrollees in self-funded health plans is that employers are seeking to avoid state health insurance mandates (not just for mental health, but all mandates) and other state insurance regulation since most of these plans are regulated by the U.S. Department of Labor and not by the state insurance department. Another plausible reason for employers opting to self-fund is because it can be more cost-effective for the employer as it eliminates profits paid to health insurers for assuming the financial risk.

It is important to note that the federal Mental Health Parity Law (discussed in Section One) would apply to some of those employers who self-fund in Connecticut. Furthermore, nothing prohibits employers who self-fund from providing the same level of benefits than those mandated at the state level. This information, however, is unavailable because it is not collected by any state agency.

## **Summary**

There is limited information reported at the state level on how persons covered under private sector health insurance plans access mental health services. As noted in the introduction, program review committee staff have requested information from major health insurers in the state on utilization and cost trends for mental health treatment since prior to the enactment of the parity law to measure the impact of the law.

## Section Three

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### Department of Insurance

Responsibility for ensuring that health insurance policies provide state mandated health benefits rests with the Connecticut Insurance Department, the agency charged with regulating the insurance industry in Connecticut. Because mental health parity is a legal requirement, not a specific program, the department's activities are not specifically focused on mental health coverage. Rather, the role of the insurance department is on ensuring broad compliance by health insurers with Connecticut laws and regulations, as well as the terms and conditions stated in health care contracts.

In order to understand how the department ensures compliance with the mental health parity law, committee staff focused its review on three of the nine divisions within the department – Life and Health, Market Conduct, and Consumer Affairs. The major activities of these divisions, as they relate to how the department enforces the mental health parity law, are described in this section.

#### Life and Health Division Major Activities

The Life and Health Division reviews and approves all group and individual health insurance policy forms, plans, applications, riders, and endorsements to ensure compliance with Connecticut insurance law. In addition, the division also:

- publishes an annual Consumer Report Card comparing managed care organizations across a variety of measures although none specifically relate to mental health coverage;
- licenses utilization review companies;
- administers the external appeals process;
- oversees the expedited review process for managed care organizations<sup>9</sup>; and
- processes requests for rate increases on individual and group accident and health policies (although committee staff found mental health costs are not usually separated out in rate filings, so this activity is not discussed in this report).

**Health insurance policy approval.** A key function performed by the division is approving health care policies. Each managed care contract offered in Connecticut must contain several provisions, including:

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<sup>9</sup> Connecticut law requires an expedited review process if an enrollee has been admitted to an acute care hospital and the attending physician determines that the enrollee's life will be endangered or serious injury could occur if the patient is discharged or treatment is delayed. The attending physician may transmit a request for an expedited review and if a response is not received within three (3) hours from when the request was made, it is deemed approved. CID maintains the directory and distributes it to all 32 acute care hospitals in Connecticut on a monthly basis.

- eligibility requirements;
- statement of co-pays and deductibles;
- benefits and exclusions;
- termination provisions;
- grievance procedures;
- conversion and extension of benefits; and
- out-of-area benefits, if any.

Before division staff will approve a policy, they ensure that the policy language is not deficient in any of the areas noted above and that it contains explicit language concerning any mandated covered benefit, such as mental health parity. The division staff ensure that language mirrors statutory requirements and no exclusions or limitations are noted in the policy that are contrary to law. The division staff use checklists (one for group, another for individual policies) while reviewing a policy to make sure all mandated benefits are stated in the policy (see Appendix C).

Typically before a policy is approved, there is considerable correspondence between division staff and staff employed by the health insurance company regarding compliance with Connecticut statutes and regulations. The focus of the correspondence is to require the insurer to add, delete, or modify specific policy language to ensure it conforms with all legal requirements.

*Policy amendments.* If the Connecticut General Assembly adopts a new state health insurance mandate, it is usually the responsibility of the health insurer to file a policy amendment with the division for approval and notify the enrollee of any coverage changes. The division has, on occasion, sent out a bulletin to insurers to clarify coverage requirements, but it is not routine practice.

*Copayment limits.* For several years, CID has administratively set the maximum allowable amount of copayments that individual and group health plans can require for certain health care services (some of which would include mental health). The division staff review policies to ensure compliance with the limits, which are shown in Table III-1. The limits would apply to mental health services, including specialist office visits, emergency room visits, and inpatient hospitalizations.

**Consumer Information.** State law requires health insurers to provide each enrollee with a detailed plan description that must contain a summary of benefits including: pre-authorization and utilization review procedures; utilization review statistics; the number, types, specialties, and geographic distribution of providers; procedures on filing a grievance; description of covered emergency services; the use of drug formularies; telephone numbers for obtaining additional information; notification procedures when an enrollee's primary care physician is no longer in the network; procedures for obtaining referrals to specialists; status of the National Committee for Quality Assurance (NCQA) accreditation; enrollee satisfaction information; and procedures on protecting confidentiality.

<b>Table III-1. New Copayment Limits Allowed by CID (revised as of March 2002).</b>		
<i>Service</i>	<i>Prior Limit</i>	<i>Revised Limit</i>
Primary Care Physician Office Visit	\$20	\$30
Specialist Office Visit	\$40	\$45
Urgent Care Visit	\$75	\$75
Emergency Room Visit (assumes co-payment waived if admitted)	\$75	\$150
Outpatient Surgery	\$200	\$500
Inpatient hospital	\$500/admission	\$500 per day up to \$2,000/admission
High Cost Diagnostic Test	\$0	\$200
Source: CID		

Generally, health plan enrollees are responsible for understanding the terms of their health coverage or the need to contact their personnel office or the health insurer's 1-800 number and speak to a member service representative to answer any questions. However, because a stigma still exists in obtaining mental health treatment an employee may be reluctant to ask his or her employer for additional information. Often, it falls to the mental health provider or his or her staff to be knowledgeable about various restrictions or limitations of a patient's health plan.

*Annual Consumer Report Card published by CID.* The Life and Health Division collects information and publishes a consumer report card on all managed care organizations, which permits consumer comparison across organizations. Managed care organizations annually report this information to the department. For each insurer, the report card includes:

- number of participating providers (primary care physicians, physician specialists in aggregate, hospitals, and pharmacies) located in each county;
- twelve quality measures (such as screening rates for certain diseases, and childhood immunization rates);
- overall utilization review statistics (reported by utilization review companies annually);
- results of member satisfaction survey;
- customer service information;
- enrollment figures; and
- whether or not the HMO is accredited by NCQA;

The report card does not contain any specific information on mental health providers, quality measures, or total mental health utilization review requests, denials, or enrollee appeals. Physician specialists are reported in aggregate, quality measures are focused on medical and/or physical health conditions, and none of the member satisfaction survey questions specifically deal with an enrollee's satisfaction with mental health services or ability to access an insurer's behavioral health network.

**Licensing utilization review companies.** Under Connecticut law, CID is responsible for annually licensing all utilization review companies. Managed care organizations can perform utilization review directly or can “carve out” mental health benefits, meaning that a separate company specializing in behavioral health performs utilization review for the MCO. As of December 31, 2004, there were 120 utilization review companies licensed in Connecticut; 46 of those performed utilization review for behavioral health.

Utilization review is used by all major health plans to assess medical necessity and appropriateness of treatment and to contain costs. By law, companies are required to use written clinical criteria and review procedures, known as medical protocols, which are established and periodically evaluated and updated with appropriate input from practitioners. Each health plan determines which services are subject to utilization review. Examples of treatments or services subject to utilization review include:

- inpatient hospitalization for physical and mental health treatment, including length of hospital stay;
- inpatient and outpatient surgery;
- participation in partial hospitalization and intensive outpatient mental health programs;
- outpatient treatment (usually after a certain number of visits have been exhausted); and
- outpatient services, such as physical therapy and chiropractic care.

***Utilization Review: Process and Procedures.*** The conduct of utilization review can be a contentious issue in the mental health field and is of concern to many providers, advocates, and consumers of mental health services. Providers argue that having to justify treatment plans to utilization review companies is a very time-consuming process and the reimbursement is inadequate for the amount of time they must spend, particularly for patients who need hospitalization or several treatment sessions. Providers also are frustrated because the initial point of contact within a utilization review company may be with an individual with limited mental health training, who does not have the authority to override strict medical protocol. Managed care organizations, on the other hand, believe that conducting utilization review is an important quality assurance function, and also helps contain costs by preventing medically unnecessary and/or inappropriate care.

***Utilization review requirements.*** A mental health care provider will usually know if obtaining prior authorization is required before providing treatment services or admitting a person to a hospital for inpatient mental health services depending on a patient’s health insurance. When a provider submits a utilization review request, the utilization review company makes its decision on whether to deny or approve the request based on information submitted by the treating practitioner and uses its protocols to determine the medical necessity and appropriateness of the proposed treatment. In general, the provider or the enrollee can call the utilization review company via an 800 number to determine if the procedure will be covered, and, if hospitalization is involved, the number of days preauthorized.

If a provider or enrollee does not obtain prior authorization before providing treatment, and the treatment is retrospectively considered medically necessary, he or she can still be penalized (the lesser of \$500 or a 50 percent reduction in payment is allowed by state regulation, but more stringent penalties stated in a provider's contract with the managed care organization would prevail).

*Internal appeals process.* Under Connecticut law, utilization review companies must meet certain statutorily established timeframes and procedural requirements for providing notification of its determinations. Enrollees or providers on behalf of enrollees must be notified of decisions made by the utilization review company within two business days of receipt of all information. Any determination not to authorize an admission, service, procedure or extension of stay must be in writing and include: 1) the principal reasons for the determination; 2) the procedures to initiate an appeal of the determination; and 3) the procedures to file an external appeal with the CID commissioner.

Figure III-1 shows the process that enrollees must follow to appeal utilization review denials. The first step is known as an internal appeal, when an enrollee must first dispute the utilization decision to the health plan (if the health plan has carved out mental health and substance abuse services, the appeal may be handled by the utilization review company). As shown in the figure, most health plans have two levels of internal appeal.

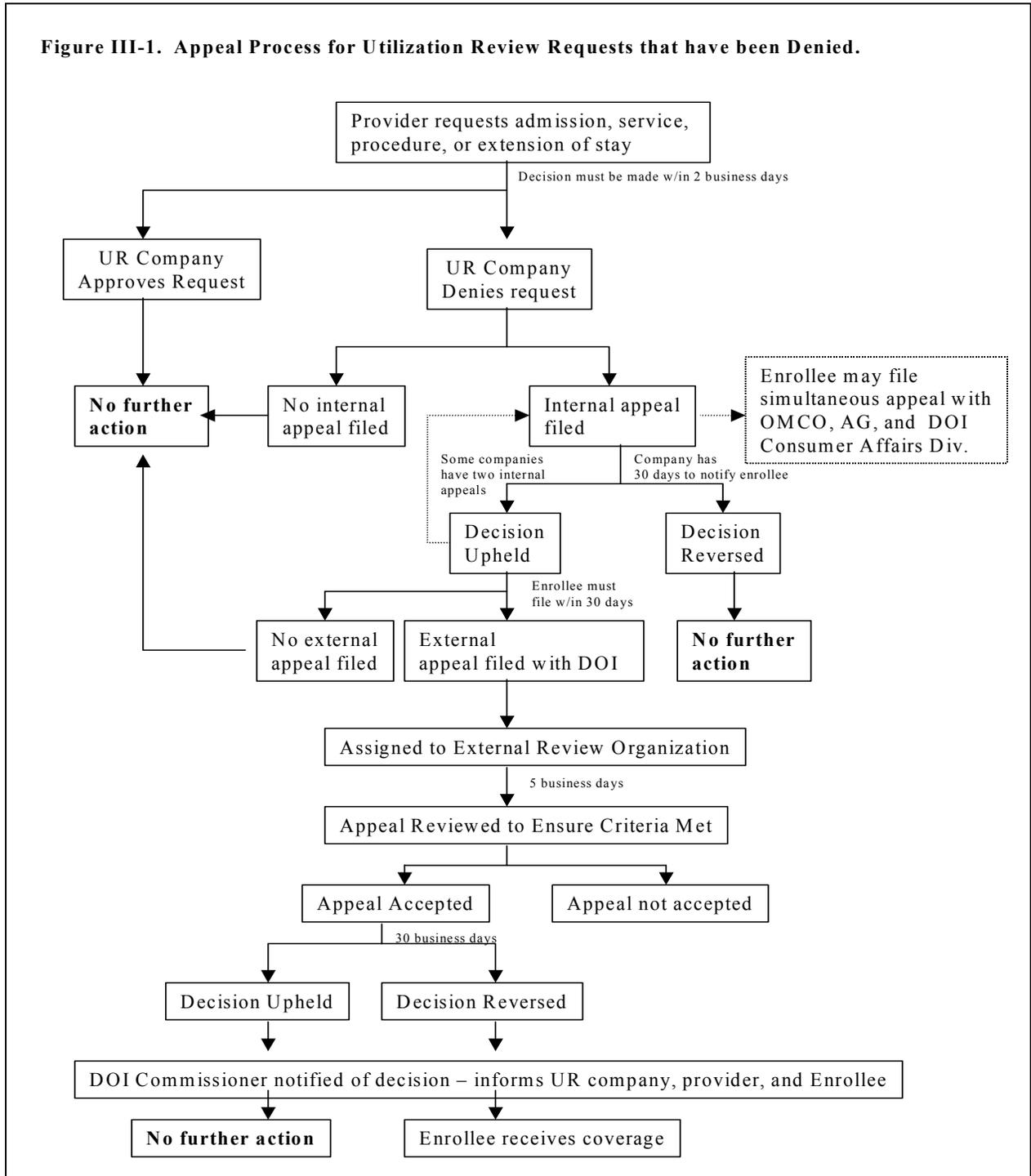
For internal appeals, the utilization review company by law has 30 days to notify the enrollee of its decision. The company also must:

- have a licensed practitioner of the medical arts make the determination;
- use written clinical criteria and review procedures that are periodically evaluated and updated with involvement from practitioners;
- have a specialist who is a specialist in the field related to the condition that is the subject of the appeal review the case if the reason not to preauthorize is based on "medical necessity" ;
- ensure the review is conducted by a practitioner, (or under the authority of a practitioner) who has a current CT license from DPH; and
- maintain documentation of the review for CID commissioner verification.

***Utilization Review Statistics: An Analysis.*** Connecticut law requires utilization review companies to annually file the number of utilization review requests submitted by providers for preauthorization of an admission, service, procedure, or extension of stay. Companies must also report the number of preauthorization requests that are denied; appealed; and the appeal outcome. In 2001, the law was amended to require utilization review determinations related to mental or nervous conditions to be reported separately from all other determinations.

Program review committee staff conducted an analysis of the utilization review statistics reported annually by each licensed utilization review company. It is important to note there are several caveats attached to the analysis of the data including:

**Figure III-1. Appeal Process for Utilization Review Requests that have been Denied.**



- the statistics are self-reported and not audited by CID;
- there is no category for partial utilization review denials (i.e., if the number of visits a provider requests are reduced by the utilization review company, that is reported to CID as a denial);
- only aggregate statistics are reported -- utilization review requests categorized by reason for the request or denial are not reported -- making analysis of the utilization review data problematic; and
- self-funded plans under ERISA and the state HUSKY B program are included in the statistics that are reported because companies do not separate out utilization review decisions of enrollees from fully-insured plans from those in self-funded plans.

Table III-2 shows statistics reported by utilization review companies on the total number of utilization reviews requested, denied, appealed, and reversed on appeal since 1998 (for both physical and mental health). The table shows the number of utilization review requests increased until 2002 and then decreased by almost one-quarter. The number of denials grew from slightly more than 28,000 to over 90,000 (221 percent) over the seven years examined, with the largest increases occurring between 1998 and 1999, and 2003 and 2004. Conversely, the table shows the number of appeals decreased over time, with 5,216 (19 percent) of denials appealed in 1998 and only 4,719 (5 percent) in 2004. Of those appealed, between 35 and 45 percent are ultimately reversed.

<b>Calendar Year</b>	<b>UR Requests</b>	<b>Denials</b>	<b>Appeals</b>	<b>Reversals</b>
1998	808,004	28,105	5,216	1,836
1999	908,576	64,586	4,837	1,928
2000	915,492	74,721	4,509	1,971
2001	951,421	69,086	4,026	1,582
2002	1,003,665	48,676	4,580	2,040
2003	907,233	63,858	4,936	2,342
2004	832,469	90,223	4,719	2,139

Source: CID

Table III-3 shows the number of utilization review requests in Connecticut specifically for mental/nervous conditions from 2001, the date that companies were statutorily required to report these figures to CID separately. In contrast to Table III-2, utilization review denials decreased 81 percent -- over the four years examined. In 2004, only 3 percent of requests received were denied compared to 23 percent in 2001. Reasons for this trend may be because many health insurers liberalized their prior authorization policies, allowing for a set number of treatments (usually between eight and 20 therapy sessions) before a provider would be required to obtain prior authorization. In addition, it is possible that because the mental health parity law mandated coverage for mental disorders defined in DSM-IV, health insurers covered more types of conditions and more individuals sought mental health services without having to undergo prior authorization.

<b>Table III-3. Mental/Nervous Condition UR Requests for CT Fully-Insured and Self Insured Enrollees.</b>				
<b>Calendar Year</b>	<b>UR Requests</b>	<b>Denials</b>	<b>Appeals</b>	<b>Reversals</b>
2001	177,879	27,558	639	207
2002	156,672	13,887	706	279
2003	208,696	6,195	521	157
2004	161,987	4,970	679	176

Source: CID

Table III-3 also shows that although small numbers of enrollees actually appeal adverse decisions, the number of appeals has been increasing relative to the number of denials. In 2001, 2 percent of denials were appealed compared to almost 14 percent in 2004. However, the percentage of decisions in favor of the appellant has been declining. Slightly more than one-quarter of the utilization review denials were reversed upon appeal in 2004 down from one-third in 2001.

Figure III-2 compares the percent of mental health utilization review requests to all requests in Connecticut. Overall, since the separate data on utilization review decisions became available in 2001, mental health utilization review requests comprise between 16 and 23 percent of all requests.

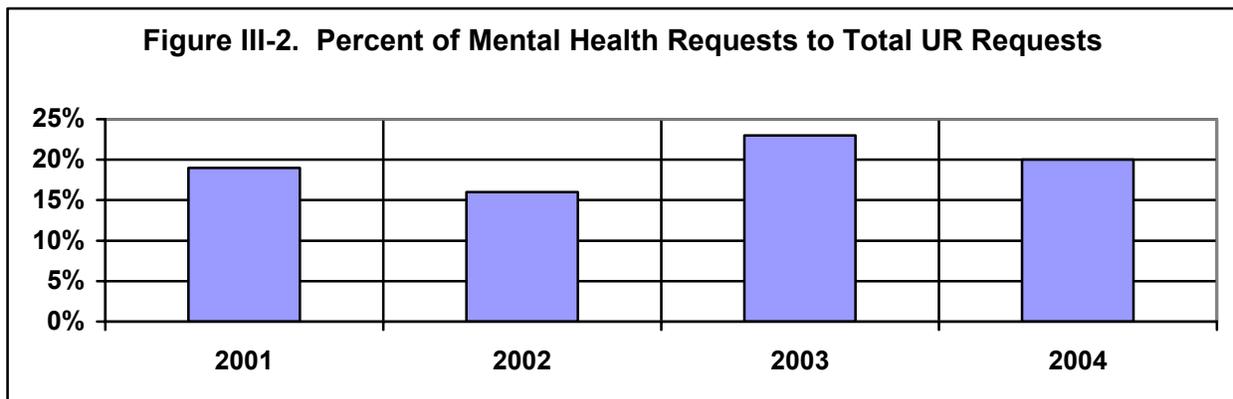


Figure III-3 shows the number of utilization review requests that were denied by mental health and non-mental health requests. As shown in the figure, the number of denials for mental health treatment has dropped from 16 percent to 3 percent between 2001 and 2003 and appears to have leveled off; in contrast the number of denials for non-mental health treatment rose five percent between 2002 and 2003.

Figure III-4 shows the percent of denials appealed for mental health treatment has steadily risen since 2001 and are at the highest level in 2004, while those concerning non-mental health treatment are at their lowest. In 2001, the number of non-mental health utilization review decisions appealed was four times greater than mental health utilization review denials. Given that the number of utilization review requests for mental health treatment has decreased since 2001 (see Figure III-3), possible reasons for the increase in appeals may be that individuals in

need of mental health services or providers on their behalf are more aware of the external appeal process and are willing to pursue this avenue to try and obtain services.

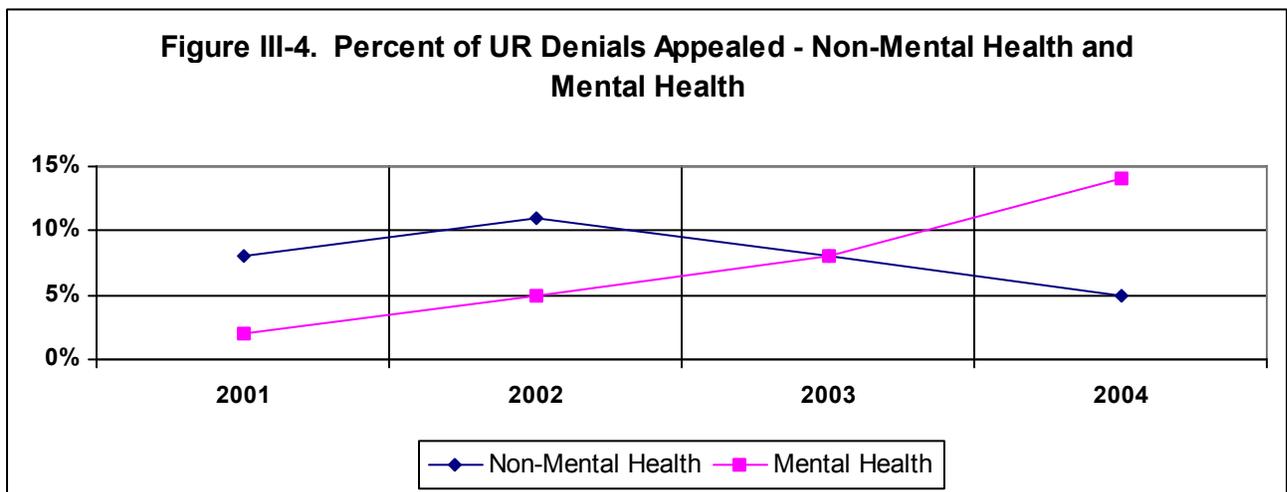
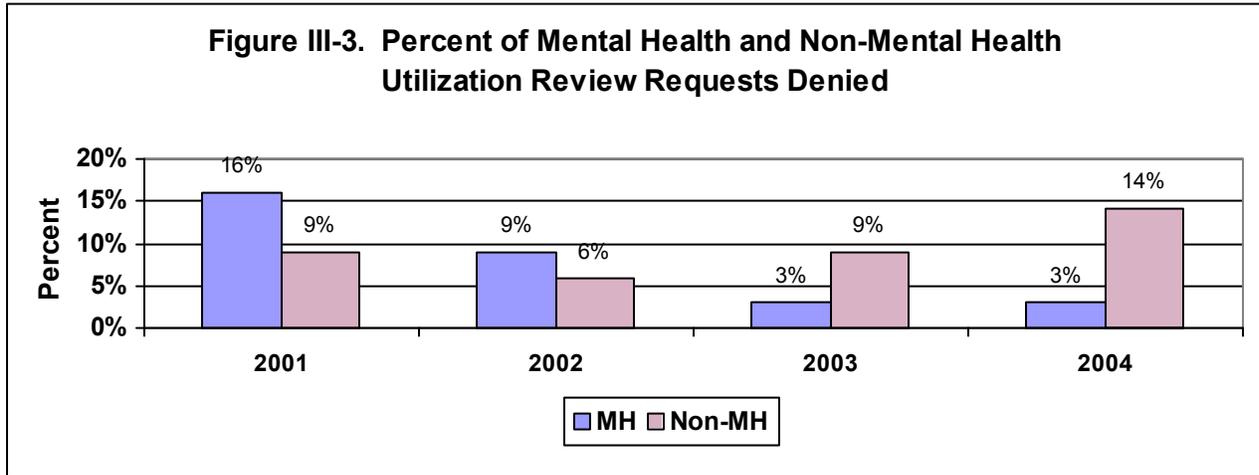
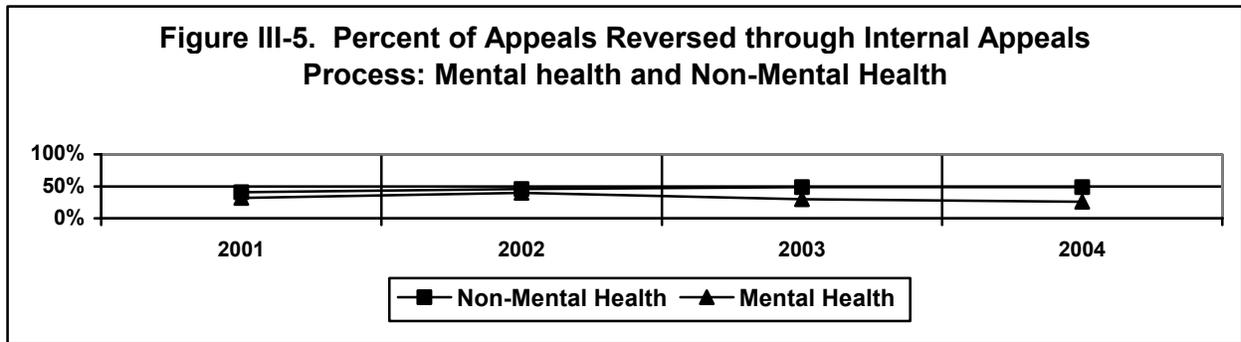


Figure III-5 compares the percent of appeals reversed during the internal appeal process. (Insurers are not required to report at what level of appeal a decision was reversed or upheld if they have more than one level). In 2004 almost 50 percent of the denial decisions were reversed on appeal for physical conditions, less than 30 percent of MH appeals were reversed.

As noted above, if an individual (or his or provider) appeals a denial and is unsuccessful under the internal appeal process, he or she may file an external appeal with the CID commissioner. Furthermore, an enrollee or provider at any point in the process may simultaneously complain to the Department Of Insurance’s Consumer Affairs Division, the Office of the Attorney General Health Care Advocacy Unit, or the Managed Care Ombudsman. These agency roles are discussed in the next section.



**CID external appeal process.** Another important function of the Life and Health Division is to oversee the external appeals process. Connecticut law (C.G.S. Sec. 38a-478n) gives enrollees who are covered under fully insured managed care plans the opportunity to appeal denials by their utilization review companies with the commissioner of insurance. To be eligible for the external appeal process the following requirements must be satisfied:

- the internal appeal process must be exhausted (the utilization review company acting on behalf of a health plan is required to provide the enrollee with written notification that the internal appeal process is exhausted);
- a "Request for External Appeal" form must be received from an enrollee by the insurance department within 30 days of receiving the written notification that the internal appeals have been exhausted;
- the individual must be actively enrolled in a health care plan at the time the service was requested as well as when the service was provided;
- the external appeal may be used only for a service or procedure that is covered in the contract;
- the denial of medical treatment or services must be based on "medical necessity"; and
- the appeal cannot be for workers' compensation claims, "self-insured" plans, Medicaid, Medicare or a Medicare Risk program.

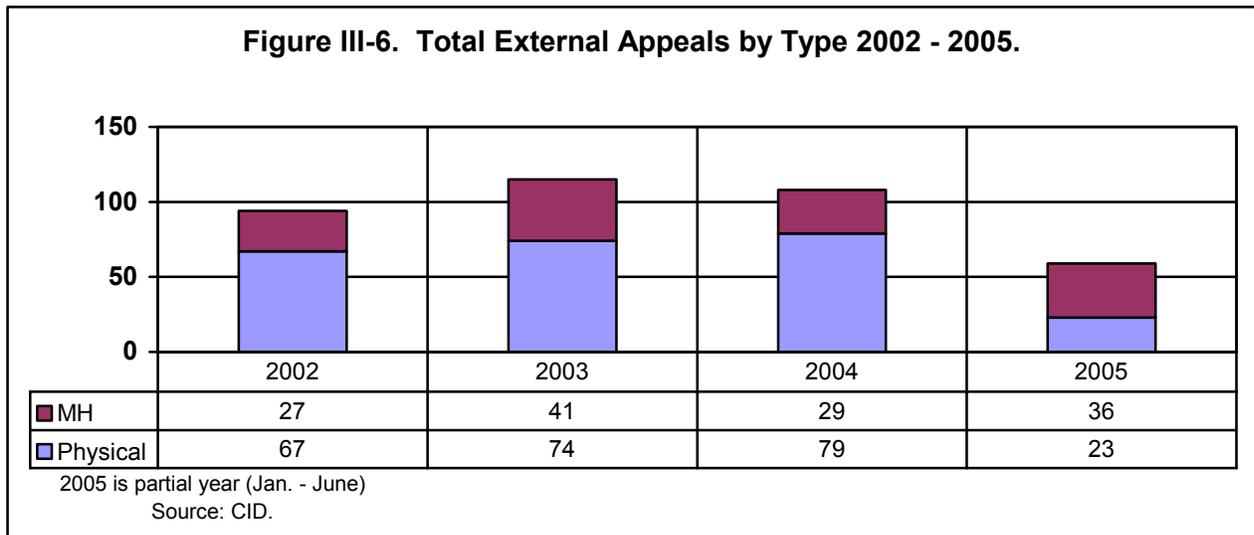
Requests for external appeals may be filed for retrospective claims denied when a service that was not subject to prior approval is denied as not "medically necessary" when the claim is submitted.

Referring back to Figure III-1 on page 18, if the insurance department receives a request for an external appeal, it is assigned to one of three external appeal organizations, under contract with CID. The organization reviews the request and determines, based on the above criteria, whether it will be accepted for a full review. Reasons that a request would be rejected include: the request was sent in too late; the service was not covered under the individual's health plan; the appeal did not involve a determination of medical necessity; or the health insurance company's internal appeal process was not exhausted. If the appeal is accepted for a full review, a decision is rendered within 30 business days. The organization can reverse, revise, or uphold the decision of the utilization review company.

The external review must be performed by a provider who is a specialist in the field related to the condition that is the subject of the appeal. The commissioner must accept the decision of the entity and the decision is binding. The reviewing provider may take into consideration:

- pertinent medical records;
- consulting physician reports;
- practice guidelines developed by the federal government, national, state or local medical societies, boards or associations; and
- clinical protocols or practice guidelines developed by the utilization review company or managed care organization.

*External appeal statistics.* Data on external appeals are only available electronically from CID since 2002. Figure III-6 shows total external appeals filed with the insurance department categorized as involving a non-mental health or mental health issue, by calendar year. Overall, with the exception of 2005 (that only has a partial year of data), there were more physical external appeal requests than for mental health. This is expected given that a higher percent of utilization review requests are denied for physical treatment than there are for mental health treatment.



As noted above, not all external appeal requests that are received by the department are ultimately accepted for review by the external review organizations. Figure III-7 shows the vast majority of appeals involving issues of mental health are accepted for review.

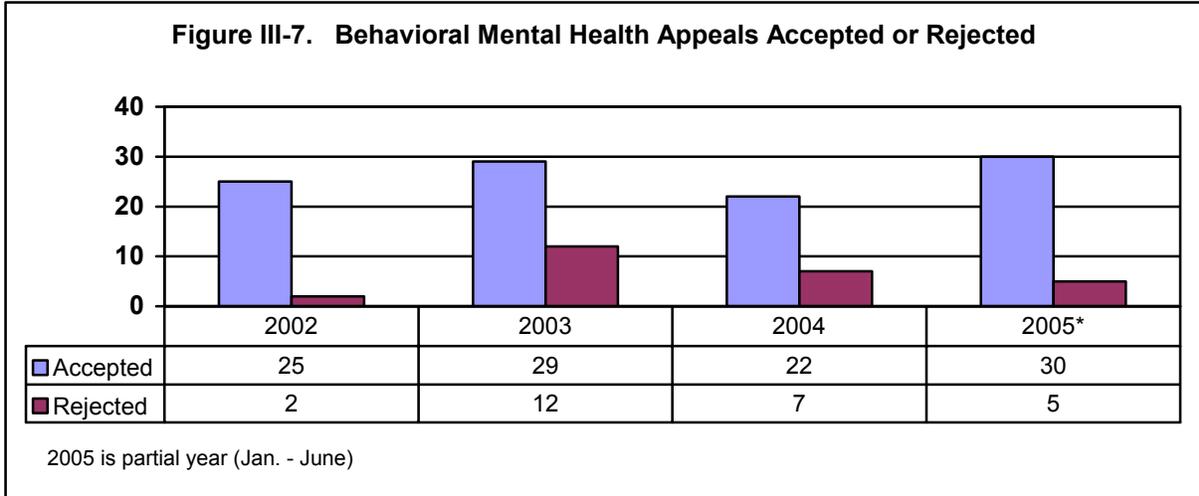
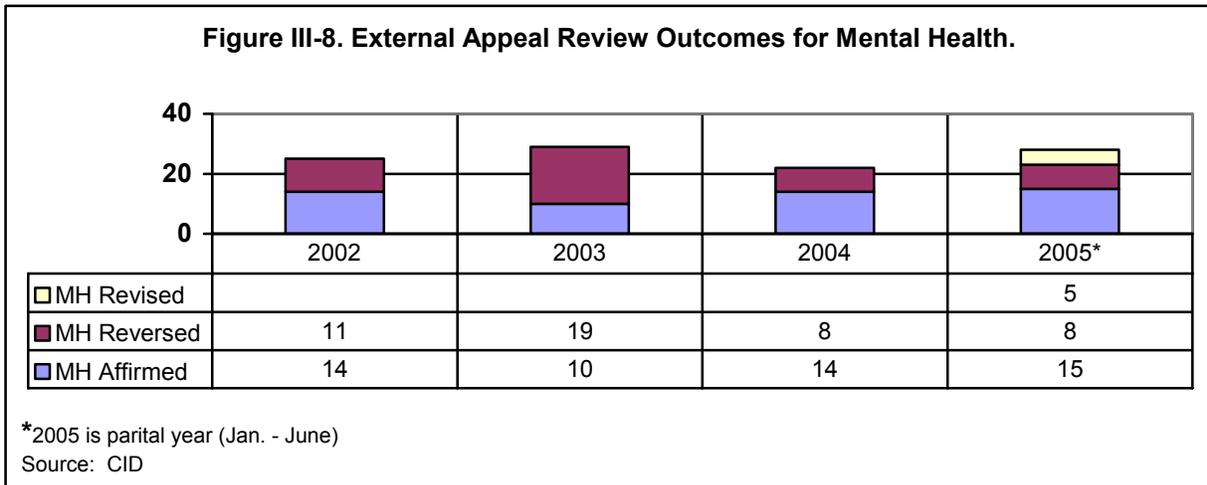


Figure III-8 compares the outcomes of the external review for cases involving mental health. The majority of decisions made by utilization review companies, with the exception of those appealed in 2003, were affirmed by the external review organization. In 2002, 56 percent of utilization review companies decisions were affirmed, 35 percent in 2003, and 64 percent in 2004. In 2005, the department created a third category “revised,” that allowed external review organizations to issue more flexible decisions allowing for companies to partially rule in favor of the appellant or company (such as requiring only partial payment for disputed coverage).



### Consumer Affairs Division

The Consumer Affairs Division of CID receives, reviews, and responds to complaints from state residents concerning their insurance and also serves as a mediator in claim disputes to determine if statutory requirements and contractual obligations within the commissioner’s jurisdiction have been met. The division also publishes an Annual Accident & Health Ranking, which lists health insurers with no justified or questionable complaints and numerically ranks those with justified and/or questionable complaints.

Although the division responds to complaints regarding any type of insurance (i.e., auto, property/casualty, etc.) it has a separate Health Insurance Unit responsible for reviewing all complaints involving managed care and utilization review companies. The division maintains a database for all complaints received. Table III-4 compares the total number of health care complaints received by the Health Care Unit to those specifically involving mental health issues since 2002, the last year data are available.

<b>Table III-4.</b>			
<b>Year</b>	<b>All Complaints</b>	<b>MH Complaints</b>	<b>% of Total</b>
2002	7,093	369	5%
2003	4,182	602	14%
2004	5,104	856	17%
2005 (ytd)	1,574	151	10%
Source: CID			

Committee staff found the vast majority of health care complaints involving mental health issues are from health care providers or consumers complaining about unfair claims practices. Since 2002, there were a total of 1,766 mental health complaints in the database that contained the source of the complaint and the reason for it. Most of the complaints (1,766 or 90 percent) concerned claims practices with 50 percent of them from insured individuals and 40 percent from providers.

Of the 1,766 complaints involving unfair claims practices, 72 percent were resolved in favor of the consumer or provider. The two most common resolutions in the database were claims settled (707 complaints) or claims settled with financial interest (560 complaints). Other possible outcomes included insufficient information provided, company position upheld, and policy not in force at time of claim.

In terms of the 156 complaints concerning utilization review, the database indicates that: the division provided information or an explanation to the complainant in 98 of the cases (63 percent); 40 cases were justified (26 percent); 8 cases the health insurer voluntarily agreed to reconsider the case (5 percent); and in 10 cases there was no action taken.

It is clear from the database that this division is not responding to many complaints concerning mental health utilization review concerns. However, CID is not the only state agency that accepts and responds to health care complaints. Both the Office of the Attorney General Health Care Advocacy Unit, and the Office of the Managed Care Ombudsman also receive and respond to health care inquiries and complaints. The complaint handling activities of these two entities, as they relate to mental health parity, are discussed in the next section.

### **Market Conduct Division**

The Market Conduct Division's major function is to protect policyholders by detecting patterns and practices that indicate a company is operating contrary to laws or regulations. Claims settlement, cancellation, and pricing practices are closely investigated. The behavior of a

insurance company in the marketplace in pricing its product, advertising, claims handling, and underwriting are all facets of a company's market conduct.

The focus of the market conduct examination is different depending on whether the division's review is of a health insurer or a utilization review company. Market conduct examiners analyze health insurers' claims data by targeting those that are paid and denied to determine inappropriate denial of claims. In addition, the division evaluates claims paid to determine if they were paid within the 45-day statutory timeframe. Only claims paid under fully insured health plans are examined. The division takes corrective action if deficiencies are found.

The division also has a utilization review compliance program to examine the functions of utilization review companies licensed by the department. The program examines data on all licensed utilization review companies through annual surveys and performance of on-site as well as desk audits. The objective of the program is to protect the rights of health plan participants by determining if the companies licensed to perform utilization review are operating in compliance with the law.

The Market Conduct Division conducts examinations of utilization review companies to determine if the companies are:

- operating in compliance with all statutory requirements, including timeliness of decisions and notification requirements;
- adhering to confidentiality laws; and
- using appropriate medical personnel when rendering utilization review decisions.

The division reviews company protocols and procedures used to render utilization review decisions to ensure they are in written form, periodically updated to reflect changes in medicine and statute, developed with local input from appropriately licensed medical professionals, and are made available to providers upon request. Division staff do not evaluate the appropriateness of the protocol or if it was applied correctly.

In addition, examinations of utilization review companies track the percentage of denials, appeals, and overturned decisions to identify any trends or patterns, especially for a specific benefit or procedure. If the overturn rate is significant, the department can and has taken corrective action. In general, if the overturn rate is 50 percent or greater, this will automatically trigger a review and if this rate is between 25 and 50 percent, the division will look more closely to see if there is a specific procedure that is problematic.

A written report is issued at the conclusion of the examination that identifies any compliance deficiencies and remedies needed. Since 2000, the division annually reviews about four companies specific to mental health services, except in 2003 when the division targeted nine companies for review. A review of these reports found that the most frequent exceptions noted by the division for improvements or modifications of utilization review company activities involved:

- failure to comply with the statutory requirements for timely notification of the outcomes of determinations and appeals;
- failure to maintain documentation evidencing that all denials of certification were issued in writing;
- erroneous reporting of utilization review information to the insurance commissioner; and/or
- lack of proper appeal language included in the letter to the enrollee.

## **Summary**

Most of the activities of CID are not focused on ensuring the provision of mental health coverage is in accordance with the parity law, which are only a minor part of the department's broader responsibilities in regulating the health insurance industry and managed care. Although some information has been statutorily required to be reported to the department on utilization review specific to mental health, it is unaudited and not published in any of the consumer guides. Furthermore, no utilization or claim data are collected by any state agencies that would allow for measuring the levels of mental health treatment over time. However, depending on the response to the committee's request to the private health plans for utilization and claim data, analysis of trends in mental health coverage will be provided in the second phase of this study.



## Section Four

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### **Other State Agencies Receiving Mental Health Care Inquiries and Complaints**

There are multiple avenues available to consumers and providers if they have a complaint against a health insurer or utilization review company. As shown in the last section, the Department of Insurance directly handles some complaints through its Division of Consumer Affairs while the Life and Health Division administers the external review appeal process for complaints involving adverse medical necessity determinations. Two other state agencies -- the Office of Attorney General's Health Care Advocacy Unit and the Managed Care Ombudsman -- also receive health care complaints. An analysis of the complaints received by each of these offices is provided in this section.

#### **Office of the Attorney General**

On November 10, 1997 the Attorney General announced the formation of a Health Care Fraud/Whistleblower Division. Responsibilities under this division were expanded in 1998 to include a Health Care Advocacy Unit. The Health Care Advocacy Unit consists of three staff (two attorneys and a paralegal) who assist consumers and health care providers by resolving disputes with managed care companies. The unit advocates on behalf of patients, including participating in the internal appeal process and helping enrollees write complaint letters to insurers and utilization review companies.

The Attorney General's Office has no specific statutory authority to investigate health care complaints, but derives it as part of its broader consumer protection authority. The unit is different from the CID because it accepts all complaints from Connecticut consumers regarding health care coverage, including those from enrollees of self-funded plans.

The unit maintains a database of the complaints it receives and uses it primarily for case tracking purposes. There are three important caveats associated with it. First, not every case was entered into the system, particularly in the earlier years (the database dates back to 1998), although unit staff believes the majority of cases are captured. Second, many of the cases in the database contain specific descriptions of each complaint and outcome so that much of the information could not be aggregated for analytical purposes by program review committee staff. Furthermore, even when there is a category that could be aggregated, there were so many choices conclusions were difficult to make (there are 66 choices for "subject" and some of categories overlap). Finally, some information was not filled in and therefore not enough information could be gleaned to include in the analysis. Given these limitations, the number of mental health cases identified by program review committee staff are most likely underrepresented in the analysis below.

Altogether there were a total of 4,366 complaints in the unit database from 1998 through June 2005 but case dispositions were missing in 1,526 cases. The "subject" category identified 167 cases as "mental health" complaints and almost all of these concerned "medical necessity" decisions. An additional 173 complaints that were classified in other subject categories were reassigned by program review committee into the mental health category (but retained the

original assignment as a subcategory) for a total of 340 mental health complaints. The reclassified complaints concerned issues of medical necessity; late claim payments; denial of claim (after a service or treatment was provided); or benefit design disputes (whether coverage existed for a specific service or treatment). Case dispositions were missing in 166 of these cases.

Program review committee staff will continue to work with the Health Care Advocacy Unit to aggregate data on the type and disposition of mental health complaints identified in the database.

### **Office of the Managed Care Ombudsman**

The Office of Managed Care Ombudsman (OMCO) was created in 1999 by the Connecticut General Assembly with passage of Public Act 99-284 "An Act Concerning Managed Care Accountability". The office has a full-time staff of three -- ombudsman, director of consumer affairs, and a secretary. A Deputy Director position was eliminated by executive action in 2003. The office is located within the Connecticut Insurance Department for administrative purposes only.

The office was created to promote and protect the interests of covered persons under managed care health plans in Connecticut. The office staff:

- assist consumers in making informed decisions when selecting a health plan;
- help consumers resolve problems with their health insurance plans; and
- identify issues that may require legislative remedies.

The office has no sanction authority but can refer complaints to the Department of Insurance for regulatory action.

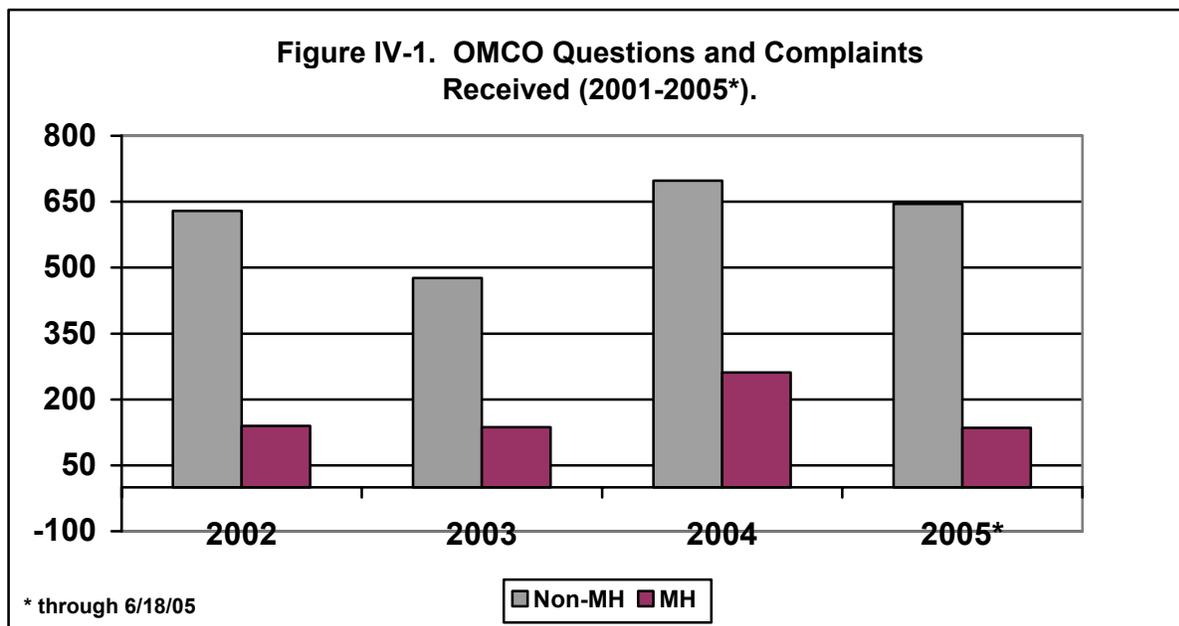
A major responsibility of the office involves educating consumers about their rights and informing them on how to advocate on their own behalf when they have a problem or concern about their managed care health plan. The office answers questions and assist consumers in understanding and exercising their rights to appeal a denial of a benefit or service made by the managed care plan. The office does not usually handle complaints from individuals in self-funded health plans, but will provide additional information to the complainant and/or refer them to the U.S. Department of Labor.

Based on a recommendation in the Lieutenant Governor's Mental Health Cabinet Report, additional responsibilities were given to the office under Public Act 05-289. This act requires OMCO, in consultation with the Community Mental Health Strategy Board, to establish a process to provide ongoing communication among mental health care providers, patients, state-wide and regional business organizations, managed care companies and other insurers to assure: 1) best practices in mental health treatment and recovery; 2) compliance with state insurance laws governing (a) guaranteed availability and renewability of coverage, mental health parity, and discrimination based on health status, (b) standards concerning psychotropic drug coverage, and (c) coverage continuation for children with mental; and 3) the relative costs and benefits of providing effective mental health care coverage to employees and their files. The ombudsman is

required to report to the public health and insurance committees by January 1, 2006, and annually thereafter on the implementation of the act. To date, a Mental Health Parity Work Group has been convened, an initial meeting was held in June, and another is scheduled for late September.

The Office of the Managed Care Ombudsman maintains a database of inquiries and complaints it receives. Information is separately maintained on inquiries and complaints received from individuals enrolled in self-funded health plans and these are excluded from the analysis presented below.

Figure IV-1 compares the number of non-mental health consumer questions and complaints received to those involving a mental health insurance issue since 2002, the last year for which data was available electronically. Overall, OMCO has experienced an increase of 25 percent -- from 2002 to 2004 -- in the number of questions and complaints it handles. The majority of inquiries and complaints received by the office involve non-mental health issues. However, the mental health inquiries and complaints are growing at a much faster rate – an 86 percent increase from 2002 to 2004 compared to only a 3 percent increase in non-mental health issues. Further, the number of mental health complaints for the first half of 2005 already has exceeded those received for all of 2002 and 2003.

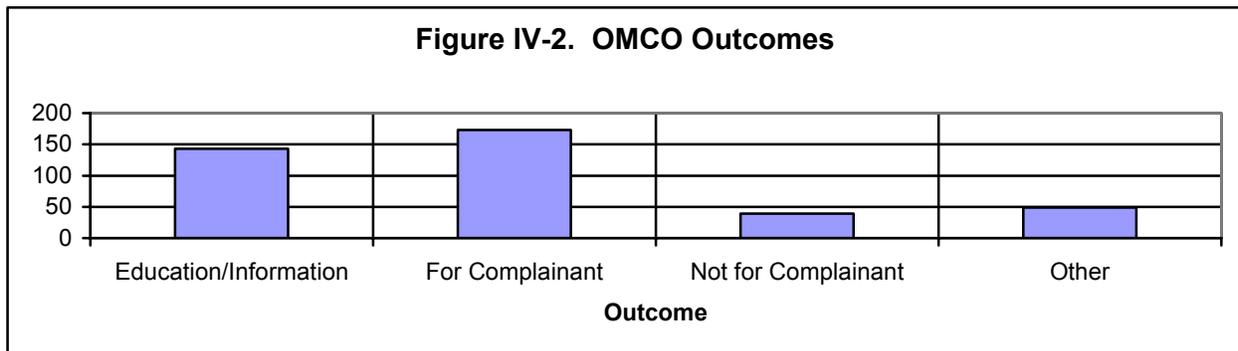


Since 2002, the office has received a total of 673 questions and complaints concerning mental health insurance coverage. There were 32 possible categories to choose from in the database identifying the “type of issue.” Program review committee staff reclassified the data contained in these categories into seven broader categories (shown in Table IV-1). The table shows those involving utilization review, and billing and claims denial are the two most common.

<i>Type of Issue</i>	<i>Frequency</i>	<i>Percent</i>
Benefit Design (Coverage)	87	13%
Billing and Claims Denial	179	27%
Utilization Review	237	35%
Education/Counseling	24	4%
Enrollment/Eligibility	26	4%
Poor Customer Service	40	6%
Other	80	12%
Total	673	101%*

\*adds up to more than 100 percent due to rounding  
Source: OMCO database.

The database used by the ombudsman to capture inquiries and complaints contains 15 outcome categories. Committee staff collapsed these categories into four broader outcome categories (shown in Figure IV-2). Outcome data were available for only 404 of the 673 cases.



Committee staff also specifically examined outcomes for utilization review, and billing and claim denial complaints. There were 237 utilization review complaints received by OMCO, 95 (40 percent) had no final outcome entered in the database; 69 cases (17 percent) were resolved in favor of the complainant, 49 cases (21 percent) resulted in information being provided, and 24 cases had other outcomes including no further contact by complainant. There were 179 complaints about billing and claims denial of which 70 cases had no outcome information, 70 cases were resolved in favor of the complainant, education was provided in 21 cases, and 18 had other outcomes.

### Summary

There are four separate state entities that receive and respond to health care complaints. Each database is unique and maintained separately with different categories used to capture the nature and outcome of health care complaints submitted by providers and consumers. Obtaining a complete picture of the complaint activity occurring at the state level and identifying trends across agencies is difficult because of the lack of integration, as well as communication among state agencies handling the complaints.

# **APPENDICES**



## APPENDIX A

### STATE MENTAL HEALTH PARITY LAWS

State n=33	Eligible Population	Coverage Requirements	Cost Containment and Other Provisions
<b>Alabama (2002)</b>	<b>Mandated offering for</b> small groups and individuals	Services for treatment of <b>“biologically-based mental disorders”</b> only	
<b>Arkansas (1997)</b>	Groups > 50 employees	Services for treatment of <b>“mental illnesses and developmental disorders”</b> as defined in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders or DSM	<ul style="list-style-type: none"> <li>• Health plans must provide mental health benefits under same terms as for other medical illnesses</li> <li>• Health plans may use a carve-out arrangement, prior authorization and other managed care techniques</li> <li>• <b>Exemption</b> if health plan’s actuary determines costs would raise average premium rates by &gt; 1.5%</li> </ul>
<b>California (1999)</b>	All employer groups/ Individuals	Services for treatment of: <ul style="list-style-type: none"> <li>• <b>“severe mental illness”</b> (schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, autism, anorexia nervosa and bulimia)</li> <li>• <b>“serious emotional disturbances of a child”</b> (one or more mental disorders as defined in the DSM, except substance abuse or developmental disorders that result in inappropriate behavior)</li> </ul>	Health plans may use case management, networks, UR techniques, prior authorization, copayments or other cost-sharing arrangements
<b>Colorado (1997)</b>	All employer groups	Services for treatment of <b>“biologically-based mental disorders”</b> (schizophrenia, affective disorder, bipolar disorder, major depression, obsessive-compulsive disorder and panic disorder)	Health plans must provide coverage of biologically-based mental illness that is no less extensive than for other physical illness

State	Eligible Population	Coverage Requirements	Cost Containment and Other Provisions
<b>Connecticut</b> (1997, 1999)	All employer groups	<ul style="list-style-type: none"> <li>• Services for treatment of “<b>mental and nervous conditions</b>” (mental disorders as defined in DSM, including <b>substance abuse</b>)</li> <li>• <b>excludes</b> mental retardation, learning disorders, motor skills disorders, communication disorders, caffeine-related disorder, relational problems)</li> </ul>	<b>Requires Full Parity:</b> No policy shall establish any terms or conditions that place greater financial burden on enrollees seeking diagnosis or treatment of mental or nervous conditions
<b>Delaware</b> (1998, 2001)	All employer groups/ Individuals	Services for treatment of “ <b>biologically-based mental disorders</b> ” (schizophrenia, schizoaffective disorder, bipolar disorder, obsessive-compulsive disorder, major depression, panic disorder, anorexia nervosa, bulimia nervosa and delusional disorder) and treatment for <b>drug and alcohol dependencies</b>	Health plans may provide services in a managed care setting and evaluate requests for coverage based on medical necessity principles
<b>Georgia</b> (1998)	<b>Mandated offering</b> for All employer groups/ Individuals	<ul style="list-style-type: none"> <li>• Mental health coverage for individuals for no more than 30 days and 48 visits per year</li> <li>• Mental health coverage for groups comparable to that of other physical illnesses covered under a health plan’s contract</li> </ul>	<ul style="list-style-type: none"> <li>• Health plans may set day and visit limits on coverage for small groups (&lt; 50 employees)</li> <li>• Health plans may carve out mental health services and deliver in managed care setting</li> <li>• Requires DOI to study mandate’s effect on premiums</li> </ul>
<b>Hawaii</b> (1999)	All employer groups	Services for treatment of “ <b>serious mental illness</b> ” (schizophrenia, schizoaffective disorder and bipolar disorders)	<ul style="list-style-type: none"> <li>• Proportion of deductibles/copayments may not be greater than those applied to comparable physical illness</li> <li>• Allows health plans to set durational limits that are actuarially equivalent to mental health benefits required</li> </ul>

State	Eligible Population	Coverage Requirements	Cost Containment and Other Provisions
<p><b>Illinois</b> (2001)</p>	<p>Large groups (&gt;50 employees)</p>	<p>Services for treatment of “<b>serious mental illness</b>” (schizophrenia, paranoid and other psychotic disorders, bipolar disorders, major depressive disorders, schizoaffective disorders, pervasive developmental disorders, obsessive-compulsive disorders, childhood depressions, and panic disorder)</p>	<ul style="list-style-type: none"> <li>• Health plans must provide coverage for treatment of serious mental illnesses under the same terms and conditions as coverage related to other illnesses and diseases</li> <li>• Upon request of health plan, providers must furnish data that substantiate that treatment is medically necessary</li> <li>• Directs DOI to prepare cost-benefit impact study for legislature by March 2005; mandate will sunset end of 2005</li> </ul>
<p><b>Indiana</b> (1999)</p> <p>(2001)</p>	<p>Large groups (&gt; 50 employees/ Individuals</p> <ul style="list-style-type: none"> <li>• Mandated requirement for group products</li> <li>• <b>Mandated offering</b> for individuals</li> </ul>	<p>Services for treatment of “<b>mental illness</b>” as defined in a health plan’s contract</p> <p>Services for treatment of pervasive developmental disorders, including autism and Asperger’s syndrome</p>	<ul style="list-style-type: none"> <li>• Treatment limits or financial requirements on coverage for mental illness must be same as for medical/surgical conditions</li> <li>• <b>Exemption</b> if an employer’s premium increases by more than 4%</li> </ul> <p>Coverage may not be subject to dollar limits or cost-sharing provisions that are less favorable than those which apply to physical illnesses</p>
<p><b>Kansas</b> (2001)</p>	<p>All employer groups</p>	<p>Services for treatment of “<b>mental illness</b>” (schizophrenia, schizoaffective disorder, reactive and atypical psychosis, delusional disorder, major affective disorders, dysthymic disorders, obsessive-compulsive disorder, panic disorder, and pervasive developmental disorder including autism)</p>	<ul style="list-style-type: none"> <li>• Such coverage shall be subject to same deductibles, coinsurance and other limits as apply to other covered services, <b>except</b> a health policy is in compliance if it includes 45 inpatient days and 45 outpatient visits per year</li> </ul>

State	Eligible Population	Coverage Requirements	Cost Containment and Other Provisions
<b>Kentucky</b> (2000)	Groups > 50 employees	<ul style="list-style-type: none"> <li>Services for treatment of “<b>mental health conditions</b>” (any condition or disorder that involves mental illness or <b>alcohol and other drug abuse</b> that falls under any of the diagnostic categories listed in DSM)</li> <li><b>excludes</b> pervasive developmental disorders (except autism), behavioral disorders, learning disabilities, retardation and caffeine/nicotine addiction</li> </ul>	<ul style="list-style-type: none"> <li>Health plans must provide coverage of any treatment for a mental health condition under same terms as for a physical health condition</li> <li>Insurance Commissioner must submit an annual report on Act’s cost impact</li> </ul>
<b>Louisiana</b> (1999)	All employer groups	Services for treatment of “ <b>severe mental illness</b> ” (schizophrenia or schizoaffective disorder, bipolar disorder, autism, panic disorder, obsessive-compulsive disorder, major depressive disorder, anorexia, bulimia, Asperger’s disorder, intermittent explosive disorder, post-traumatic stress disorder, Rett’s disorder, and Tourette’s disorder)	Specifies that a health policy is in compliance if benefits include 45 inpatient days and 52 outpatient visits per year
<b>Maine</b> (1995, 2003)	<ul style="list-style-type: none"> <li>Mandated requirement for large groups (&gt; 20 employees)</li> <li><b>Mandated offering</b> for small groups and individuals</li> </ul>	Services for treatment of “ <b>mental health conditions</b> ” (psychotic, dissociative, mood, anxiety, personality and tic disorders; paraphilias; attention deficit and pervasive developmental disorders; bulimia, anorexia; and substance abuse-related disorders)	Proportion of deductibles/copayments for mental health services may not be greater than those applied to comparable physical illness
<b>Massachusetts</b> (2000)	All employer groups/ Individuals	<ul style="list-style-type: none"> <li>Services for treatment of “<b>biologically-based illnesses</b>” (schizophrenia, bipolar disorder, or any other condition so defined in the DSM)</li> <li>Services for rape-related mental or emotional disorders, once costs exceed \$25,000</li> </ul>	Health plans must treat mental illnesses in the same manner as physical illnesses

State	Eligible Population	Coverage Requirements	Cost Containment and Other Provisions
<b>Maryland</b> (1994)	All employer groups/ Individuals	Services for treatment of <b>mental illnesses, emotional disorders, drug abuse and alcohol abuse</b> which in professional judgment of practitioners is medically necessary and treatable	<ul style="list-style-type: none"> <li>• Coverage for inpatient mental health benefits must be on same terms as for physical illness</li> <li>• Cost-sharing for outpatient visits rises with utilization: 80% for first 5 visits; 65% for 6<sup>th</sup>-30<sup>th</sup> visit; and 50% thereafter</li> <li>• Authorized benefits to be subject to a managed care system</li> </ul>
<b>Minnesota</b> (1994)	All employer groups/ Individuals	Services for treatment of “ <b>mental health and chemical dependency</b> ” as defined in a health plan’s contract	<b>Requires Full Parity:</b> Cost-sharing requirements and benefit limitations for inpatient and outpatient mental health and chemical dependency services must not place a greater financial burden on enrollees or be more restrictive than for medical services
<b>Missouri</b> (1997, 1999, 2004)	All employer groups  <b>Mandated offering</b> only for individuals	<ul style="list-style-type: none"> <li>• Services for treatment of “<b>mental illness</b>” defined as disorders recognized in the DSM (except mental retardation)</li> <li>• Also provides for a second, catastrophic coverage option limited primarily to biologically-based disorders</li> </ul>	<ul style="list-style-type: none"> <li>• Health plans may set durational limits for treatment of substance abuse</li> <li>• Health plans may deliver services on a managed care basis and determine medically necessary and clinically appropriate care</li> <li>• <b>Exemption</b> if compliance increases premium by &gt; 2% over two years</li> </ul>
<b>Montana</b> (1999)	All employer groups/ Individuals	Services for treatment of “ <b>severe mental illness</b> ” (schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder and autism)	<ul style="list-style-type: none"> <li>• Health plans must provide benefits for severe mental illness that are no less favorable than for other physical illnesses</li> <li>• Benefits may be subject to managed care provisions contained in a contract</li> </ul>

State	Eligible Population	Coverage Requirements	Cost Containment and Other Provisions
<p><b>Nebraska</b> (1999)</p>	<p>Large groups (&gt; 15 employees)</p>	<p>Services for treatment of “<b>serious mental illness</b>” (schizophrenia, schizoaffective disorder, delusional disorder, bipolar disorder, major depression and obsessive compulsive disorder)</p>	<ul style="list-style-type: none"> <li>• Health plans may not place a greater financial burden on an enrollee for serious mental illness than for treatment of a physical health condition</li> <li>• Health plans may use managed care techniques to determine and arrange for medically necessary and clinically appropriate mental health care</li> </ul>
<p><b>New Hampshire</b> (1994, 2002)</p>	<p>All employer groups</p>	<p>Services for treatment of “<b>biologically-based mental illnesses</b>” (schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, autism, anorexia nervosa, bulimia nervosa, and post-traumatic stress disorder)</p>	<p>Coverage for biologically-based mental illness must be provided under same terms and be no less extensive than care for physical illness</p>
<p><b>New Jersey</b> (1999)</p>	<p>All employer groups/ Individuals</p>	<p>Services for treatment of “<b>biologically-based mental illness</b>” (schizophrenia, Schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and autism)</p>	<p>Terms of coverage for biologically-base mental illness must be same as for medical/surgical care with respect to cost-sharing and benefit limits</p>
<p><b>New Mexico</b> (2000)</p>	<p>All employer groups</p>	<p>“<b>Mental health benefits</b>” means benefits as described in the health plan’s contract</p>	<ul style="list-style-type: none"> <li>• Health plans may not impose limits or financial requirements on mental health benefits if identical terms are not imposed for other conditions</li> <li>• <b>Exceptions allowed</b> for small groups (2-49 employees) if premiums rise &gt; 1.5% and for large groups if premiums rise &gt; 2.5% (i.e., higher employee cost-sharing or reduced coverage)</li> </ul>

State	Eligible Population	Coverage Requirements	Cost Containment and Other Provisions
<b>Oklahoma</b> (1999)	Large groups (> 50 employees)	Services for treatment of “ <b>severe mental illness</b> ” (schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder and obsessive-compulsive disorder)	<ul style="list-style-type: none"> <li>• Coverage of severe mental illness must be subject to same prior authorization and UR</li> <li>• <b>Exemption</b> if group’s premium rises 2% after first year</li> <li>• Requires DOI to analyze cost impact and report by December 2002; mandate will sunset if cumulative premiums rise &gt; 6% after three years</li> </ul>
<b>Oregon</b> (1987)	All employer groups	Services for treatment of mental or nervous conditions and <b>chemical dependency</b> (except tobacco-related addictions)	<ul style="list-style-type: none"> <li>• Requires parity <b>only for cost-sharing</b></li> <li>• Specifies that a health plan is in compliance if annual benefit payments are no less than \$10,500 for adults and \$12,500 for children</li> </ul>
<b>Rhode Island</b> (1994, 2001)	All employer groups/ Individuals	<ul style="list-style-type: none"> <li>• Services for treatment of “<b>any mental disorder and substance abuse disorder</b>” as defined in the DSM</li> <li>• <b>excludes</b> mental retardation, learning disorders, motor skills disorders, communication disorders, and tobacco/caffeine-related addictions</li> </ul>	<ul style="list-style-type: none"> <li>• Limits coverage for outpatient services to 30 visits in a calendar year</li> <li>• If a provider cannot establish medical necessity, neither health plan nor patient shall be obligated to reimburse</li> <li>• Mandate only applies to mental health services delivered by in-state facilities</li> </ul>
<b>South Dakota</b> (1998)	All employer groups	Services for treatment of “ <b>biologically-based mental illnesses</b> ” (schizophrenia and other psychotic disorders, bipolar disorder, major depression and obsessive-compulsive disorder)	Coverage for biologically-based mental illnesses must have same dollar limits, deductibles, coinsurance factors and restrictions as for other covered illnesses
<b>Tennessee</b> (1998)	Large groups (> 25 employees)	Mental health coverage shall provide a minimum of 20 inpatient days and 25 outpatient visits	<ul style="list-style-type: none"> <li>• Health plans must apply same deductibles and co-payments to mental health services as for physical illnesses</li> <li>• <b>Exemption</b> if premiums rise by 1%</li> </ul>

State	Eligible Population	Coverage Requirements	Cost Containment and Other Provisions
<p><b>Texas</b> (1997)</p>	<p>Mandated requirement for large groups (&gt; 50 employees)</p> <p><b>Mandated offering</b> for small groups (2-50 employees)</p>	<p>Services for treatment of “<b>serious mental illness</b>” (schizophrenia, schizoaffective disorders, paranoid and other psychotic disorders, bipolar disorder and major depression)</p>	<ul style="list-style-type: none"> <li>• Health plans must provide mental health coverage of 45 inpatient days and 60 outpatient visits annually based on medical necessity</li> <li>• Health plans must impose same amount limits and cost-sharing for serious mental illness as for physical illness</li> </ul>
<p><b>Utah</b> (2000)</p>	<p><b>Mandated offering</b> for All employer groups</p>	<ul style="list-style-type: none"> <li>• Services for treatment of “<b>mental illness</b>” as defined in the DSM</li> <li>• <b>excludes</b> relational problems, social maladjustment, conduct disorder, personality disorder, learning disability and mental retardation</li> </ul>	<ul style="list-style-type: none"> <li>• Health plans must offer catastrophic mental health coverage on a parity basis</li> <li>• Different cost-sharing can be applied to mental and physical illnesses, but once out-of-pocket limit is reached, coverage is provided for mental illnesses at same level as for physical illnesses</li> </ul>
<p><b>Vermont</b> (1997)</p>	<p>All employer groups/ Individuals</p>	<p>Services for treatment of “<b>mental illness and substance abuse</b>” as listed in the ICD</p>	<ul style="list-style-type: none"> <li>• <b>Requires Full Parity:</b> Coverage for mental illness and substance abuse treatment must be equal to physical health in payment limits, cost-sharing and day/visit limits</li> <li>• Health plans may require enrollees to receive benefits through managed care</li> </ul>
<p><b>Virginia</b> (1999)</p>	<p>Large groups (&gt; 25 employees)</p>	<p>Services for treatment of “<b>biologically-based mental illness and drug and alcohol addiction</b>” (schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, attention deficit disorder and autism)</p>	<ul style="list-style-type: none"> <li>• Mental health and substance abuse coverage must be same as coverage for other illnesses in terms of cost-sharing, durational limits and payment limits</li> <li>• Health plans may apply same medical necessity criteria to mental health benefits as used for other illnesses</li> </ul>

State	Eligible Population	Coverage Requirements	Cost Containment and Other Provisions
<p><b>West Virginia</b> (2002)</p>	<p>All employer groups</p>	<p>Services for treatment of “<b>serious mental illness</b>” (schizophrenia/other psychotic disorders, bipolar disorders, depressive disorders, <b>substance-related disorders</b> (except caffeine/nicotine), anxiety disorders, and anorexia/bulimia</p>	<ul style="list-style-type: none"> <li>• <b>Exemption</b> if large employer’s mental health costs increase to 2% of total costs or by 1% for small employers</li> <li>• Remedy would impose unspecified costs controls on mental health benefit</li> </ul>

Source: Blue Cross Blue Shield Association, December 2004

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## APPENDIX B

<b>Comparison of Employee Copays for Mental Health Services and Employee Share of Premiums by Plan Type.</b>			
<i>Benefit</i>	<i>POE and POI-G</i>	<i>POS In Network</i>	<i>POS Out-of-Network</i>
<b><i>Prior Authorization Required</i></b>			
Mental Health			
• Inpatient		100%	80%
• Outpatient	\$5 copay	\$10 copay	80%
Substance Abuse			
• Detoxification		100%	80%
• Inpatient		100%	80%
• Outpatient	\$5 copay	\$10 copay	80%
<b>Employee Share of Premium</b>			
<i>Type of Plan</i>	<i>Subscriber</i>	<i>Subscriber+1</i>	<i>Family</i>
<b>Point of Service</b>			
Anthem State Preferred POS	\$40.58	\$137.52	\$163.32
Anthem State Blue Care POS	\$12.22	\$68.86	\$81.26
Health Net Charter POS	\$12.45	\$70.16	\$82.80
Oxford Freedom Select POS	\$11.93	\$67.24	\$79.35
<b>Point of Enrollment (POE)</b>			
Anthem State BlueCare POE	\$5.73	\$42.54	\$60.26
Health Net Charter POE	\$5.73	\$42.54	\$60.25
Oxford HMO Select POE	\$5.35	\$41.15	\$58.28
<b>Point of Enrollment - Gatekeeper</b>			
Anthem State BlueCare POE Plus	\$3.42	\$34.88	\$47.98
Health Net Passport HMO	\$3.42	\$35.83	\$49.28
Oxford HMO	\$3.04	\$31.54	\$43.37
Source: Office of the Comptroller.			

## Appendix C Group

- UR company licensed
- 38a-478g(b) Plan description      Managed care plans

### **Required mandates**

- 38a-514                      Mental illness parity
- 38a-515 –                    Mentally or physically handicapped dependents
- 38a-516                      Newborn children
- 38a-516a                     Early intervention (Birth to 3)
- 38a-516b                    Hearing aids for children 12 and younger
- 38a-516c                    Craniofacial disorders
- 38a-517a                    In-hospital dental services
- 38a-518                      Accidental ingestion of a controlled drug
- 38a-518a                    Hypodermic needles and syringes
- 38a-518c                    Protein modified foods/formula for children up to 3
- 38a-518d                    Diabetes coverage
- 38a-518e                    Diabetes self-management training
- 38a-518g                    Prostate screening
- 38a-518h                    Lyme disease treatment
- 38a-518i                    Pain Management
- 38a-518j                    Ostomy appliances and supplies
- 38a-518k                    Colorectal cancer screening
- 38a-520                      Home health care
- 38a-524                      Occupational therapy
- 38a-525                      Emergency ambulance services
- 38a-529                      Veterans home and hospital coverage
- 38a-530 –                    Mammography
- 38a-530c                    Maternity and postpartum care
- 38a-530d                    Mastectomy
- 38a-535                      Preventive pediatric care
- 38a-537                      15 day notice of cancellation
- 38a-541                      Spousal coverage
- 38a-542                      Tumors and leukemia (incl. removal of breast implants)
- 38a-542a–g                 Cancer clinical trials
- 38a-543                      Age discrimination prohibited
- 38a-546                      Continuation of coverage
- 38a-554                      Continuation of coverage and conversion
- 38a-549                      Adopted children

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**Check for (can't be contrary)**

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- 38a-530e Contraceptives
- 38a-518b Cancer drugs not to be excluded
- “actively at work” language”
- 38a-476 and HIPAA – pre-existing conditions
- 38a-513b Def. of “experimental or investigational
- PA01-171 sec 17 Psychotropic drug availability
- 38a-530b Pap smear tests

**Optional**

- 38a-536 Infertility (not applicable to HMOs)

## Individual Mandates

- UR company licensed
- 38a-478g(b) Plan description

### **Required mandates**

- 38a-488a Mental illness parity
- 38a-489 Mentally or physically handicapped dependents
- 38a-490 Newborn children
- 38a-490a Early intervention (Birth to 3)
- 38a-490b Hearing aids for children 12 and younger
- 38a-490c Craniofacial disorders
- 38a-491a In-hospital dental services
- 38a-492 Accidental ingestion of a controlled drug
- 38a-492a Hypodermic needles and syringes
- 38a-492c Protein modified foods/formula for children up to 3
- 38a-492d Diabetes coverage
- 38a-492e Diabetes self-management training
- 38a-492g Prostate screening
- 38a-492h Lyme disease treatment
- 38a-492i Pain Management
- 38a-492j Ostomy appliances and supplies
- 38a-492k Colorectal cancer screening
- 38a-493 Home health care
- 38a-496 Occupational therapy
- 38a-498 Emergency ambulance services
- 38a-503 – Mammography
- 38a-503c Maternity and postpartum care
- 38a-503d Mastectomy
- 38a-504 Tumors and leukemia (incl.rem. of breast implants)
- 38a-504a-504g Cancer clinical trials
- 38a-508 Adopted children

### **Check for (can't be contrary)**

- 38a-492b Cancer drugs not to be excluded
- 38a-503e Contraceptives
- “actively at work” language”
- 38a-476 and HIPAA – pre-existing conditions
- 38a-483c Def. of “experimental or investigational
- PA01-171 sec 17 Psychotropic drug availability
- 38a-503b Pap smear tests

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