



## OLR BACKGROUNDER: STATE-MANDATED HEALTH INSURANCE BENEFITS

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### QUESTION

This report briefly describes Connecticut's mandated health insurance benefits. It updates an earlier report ([2012-R-0446](#)) by incorporating laws enacted in 2013 and 2014. (See OLR Report [2008-R-0138](#) for a list of health care providers and facilities whose services health insurance policies must cover under state law.)

### SUMMARY

A health insurance benefit mandate is a requirement that an insurance company or health plan cover a specified benefit. In Connecticut, private health insurance benefit mandates are contained in [Chapter 700c](#) of the General Statutes.

Each benefit mandate statute identifies the specific plans to which the mandate applies. Many of the mandates apply to both individual and group health insurance plans. However, due to the federal Employee Retirement Income Security Act (ERISA), state benefit mandates generally do not apply to self-funded plans. For more information about ERISA preemption, see OLR Report [2005-R-0753](#).

In 2013 and 2014, the legislature enacted the following four acts related to health insurance benefit mandates:

1. [PA 13-84](#), An Act Concerning Health Insurance Coverage for Autism Spectrum Disorders (effective upon passage, June 5, 2013).
2. [PA 13-131](#), An Act Concerning Synchronizing Prescription Refills (effective January 1, 2014).
3. [PA 13-307](#), An Act Concerning Copayments for Physical Therapy Services (effective January 1, 2015).

4. [PA 14-97](#), An Act Concerning Copayments for Breast Ultrasound Screenings and Occupational Therapy Services (effective January 1, 2015).

## CONNECTICUT'S MANDATED HEALTH INSURANCE BENEFITS

Table 1 briefly describes Connecticut's mandated health insurance benefits. It also provides the statutory citation for each and indicates whether the mandate applies to individual health insurance plans, group health insurance plans, or both.

**Table 1: Connecticut's Mandated Health Insurance Benefits\***

<b>CGS §</b>	<b>Mandate</b>	<b>Individual, Group, or Both</b>	<b>Description</b>
<a href="#">38a-498a</a> <a href="#">38a-525a</a>	911 Calls	Both	Cannot require preauthorization for 911 calls.
<a href="#">38a-492</a> <a href="#">38a-518</a>	Accidental Ingestion or Consumption of Controlled Drugs	Both	Emergency medical care for the accidental ingestion or consumption of controlled drugs. Coverage is subject to a minimum of 30 days inpatient care and a maximum \$500 for outpatient care per calendar year.
<a href="#">38a-533</a>	Alcoholism	Group	Expenses incurred in connection with medical complications of alcoholism such as cirrhosis of the liver, gastrointestinal bleeding, pneumonia, and delirium tremens.
<a href="#">38a-498</a> <a href="#">38a-525</a>	Ambulance Services	Both	Ambulance service when medically necessary. Payment must be on a direct pay basis where notice of assignment is reflected on the bill.
<a href="#">38a-514b</a> As amended by <a href="#">PA 13-84</a>	Autism Spectrum Disorder	Group	Policies must cover the diagnosis and treatment of autism spectrum disorders, including (1) behavioral therapy for a child age 14 or younger and (2) certain prescription drugs and psychiatric and psychological services. A policy can limit coverage for behavioral therapy to \$50,000 a year for a child age eight or younger; \$35,000 for a child age nine to 12; and \$25,000 for a 13- or 14-year-old.
<a href="#">38a-488b</a> As amended by <a href="#">PA 13-84</a>	Autism Spectrum Disorder	Individual	Policies must cover physical, speech, and occupational therapy services to treat autism spectrum disorder to the extent such services are covered for other diseases and conditions.
<a href="#">38a-516a</a>	Birth-to-Three Services	Group	At least \$6,400 per child annually for medically necessary early invention services, up to \$19,200 per child over three years. Coverage for children with autism spectrum disorders must be at least \$50,000 per child annually, up to \$150,000 per child over three years.  Policies cannot impose coinsurance, copayments, deductibles, or other out-of-pocket expenses for these services, unless it is a high deductible health plan used to establish a medical savings account.
<a href="#">38a-490a</a>	Birth-to-Three Services	Individual	At least \$6,400 per child annually for medically necessary early invention services, up to \$19,200 per child over three years.  Policies cannot impose coinsurance, copayments, deductibles, or other out-of-pocket expenses for these services, unless it is a high deductible health plan used to establish a medical savings account.
<a href="#">38a-492o</a> <a href="#">38a-518o</a>	Bone Marrow Testing	Both	Policies must cover compatibility testing for bone marrow transplants for people who join the National Marrow Donor Program.

Table 1 (continued)

CGS §	Mandate	Individual, Group, or Both	Description
<a href="#">38a-503</a> <a href="#">38a-530</a>  As amended by <a href="#">PA 14-97</a>	Breast Cancer Screening	Both	Baseline mammogram for a woman age 35 to 39 and one every year for a woman age 40 and older.  Additional coverage must be provided for a comprehensive ultrasound screening of a woman's entire breast(s) if (1) a mammogram shows heterogeneous or dense breast tissue based on BI-RADS or (2) the woman is at increased breast cancer risk because of family history, her prior history, genetic testing, or other indications determined by her physician or advanced-practice nurse. Coverage is subject to any policy provisions applicable to other covered services. Effective January 1, 2015, a policy cannot impose a copayment of more than \$20 for a breast ultrasound screening.  Coverage must be provided for magnetic resonance imaging (MRI) in accordance with guidelines established by the American Cancer Society.
<a href="#">38a-542(a)&amp;(b)</a>	Breast Implant Removal	Group	Medically necessary removal of breast implants implanted on or before July 1, 1994. Annual coverage must be at least \$1,000.
<a href="#">38a-504(c)</a> <a href="#">38a-542(c)</a>	Breast Reconstruction after Mastectomy	Both	Reconstructive surgery on non-diseased breast for symmetrical appearance. Coverage is subject to the same terms and conditions as other benefits under the policy.
<a href="#">38a-504a</a> – <a href="#">38a-504g</a> ; <a href="#">38a-542a</a> – <a href="#">38a-542g</a>	Cancer and Other Clinical Trials	Both	Routine patient costs relating to cancer clinical trials and disabling or life-threatening chronic diseases. Out-of-network hospitalization paid as in-network benefit if services are not available in network. Such trials must have peer-reviewed protocols approved by one of several federal organizations.
<a href="#">38a-482</a> <a href="#">38a-497</a>	Children - Covered to Age 26	Both	Coverage continues at least until the policy anniversary date on or after the date the child (1) gets coverage under his or her employer's group health plan or (2) turns age 26.
<a href="#">38a-489</a> <a href="#">38a-515</a> <a href="#">38a-554</a>	Children - Mentally or Physically Handicapped	Both	After passing dependent status age when coverage would otherwise end, coverage must continue if child is both mentally or physically handicapped and dependent upon insured for support.
<a href="#">38a-490</a> <a href="#">38a-508</a> <a href="#">38a-516</a> <a href="#">38a-549</a>	Children - Newborns and Adopted	Both	Injury and sickness, including care and treatment of congenital defects and birth abnormalities, for newborns from birth and for adopted children from legal placement for adoption.  Newborns are covered for 61 days. To extend coverage, insureds must give notification and premium payment to the insurer.
<a href="#">38a-497</a> <a href="#">38a-554</a>	Children - Stepchildren	Both	Policies must cover stepchildren on the same basis as biological children.
<a href="#">38a-492l</a> <a href="#">38a-516d</a>	Children with Cancer	Both	Coverage for children diagnosed with cancer after December 31, 1999 for neuropsychological testing a physician orders to assess the extent chemotherapy or radiation treatment has caused the child to have cognitive or developmental delays. Insurers cannot require pre-authorization for the tests.
<a href="#">38a-490b</a> <a href="#">38a-516b</a>	Children's Hearing Aids	Both	Hearing aids for children age 12 and under. Coverage may be limited to \$1,000 within a 24-month period.
<a href="#">38a-507</a> <a href="#">38a-534</a>	Chiropractic Services	Both	Cover chiropractor services to same extent as coverage for a physician.
<a href="#">38a-492k</a> <a href="#">38a-518k</a>	Colorectal Cancer Screening	Both	Colorectal cancer screening. Frequency of screening must be based on recommendations by the American Cancer Society.  Cannot impose coinsurance, copayment, deductible, or other out-of-pocket expense for any additional colonoscopy a physician orders for an insured person in a policy year, unless a high deductible insurance plan used to establish a medical savings account.  Cannot impose a deductible for a procedure initially undertaken as a screening colonoscopy or screening sigmoidoscopy.
<a href="#">38a-503e</a> <a href="#">38a-530e</a>	Contraceptives	Both	If prescription drugs are covered, prescription contraceptives must be covered. An employer or individual may decline contraceptive coverage if it conflicts with religious beliefs.

Table 1 (continued)

CGS §	Mandate	Individual, Group, or Both	Description
<a href="#">38a-490c</a> <a href="#">38a-516c</a>	Craniofacial Disorders	Both	Medically necessary orthodontic processes and appliances for treatment of craniofacial disorders for people age 18 or younger. Coverage is not required for cosmetic surgery.
<a href="#">38a-491a</a> <a href="#">38a-517a</a>	Dental Coverage	Both	Medically necessary general anesthesia, nursing, and related hospital services for in-patient, outpatient, or one-day dental services.
<a href="#">38a-492d</a> <a href="#">38a-518d</a>	Diabetes	Both	Laboratory and diagnostic tests for all types of diabetes. Medically necessary equipment, drugs, and supplies for insulin-dependent, insulin using, gestational, and non-insulin using diabetes.
<a href="#">38a-492e</a> <a href="#">38a-518e</a>	Diabetes Self-Management Training	Both	Outpatient self-management training prescribed by a licensed health care professional. Coverage is subject to the same terms and conditions as other policy benefits.
<a href="#">38a-492n</a> <a href="#">38a-518m</a>	Epidermolysis Bullosa	Both	Policies must cover wound care supplies that are medically necessary to treat epidermolysis bullosa (a rare skin disorder) and administered under a physician's direction.
<a href="#">38a-483c</a> <a href="#">38a-513b</a>	Experimental Treatments	Both	Procedures, treatments, or drugs that have completed a Phase III Food and Drug Administration clinical trial. Appeals process expedited for those with a life expectancy of less than two years.
<a href="#">38a-493</a> <a href="#">38a-520</a>	Home Health Care	Both	Home health care, including (1) part-time or intermittent nursing care and home health aide services; (2) physical, occupational, or speech therapy; (3) medical supplies, drugs and medicines; and (4) medical social services. Coverage can be limited to no less than 80 visits per year and, for a terminally ill person, no more than \$200 for medical social services. Coverage can be subject to an annual deductible of up to \$50 and a coinsurance of no less than 75%, except that a high deductible plan used to establish a medical savings account is exempt from the deductible limit.
<a href="#">38a-492a</a> <a href="#">38a-518a</a>	Hypodermic Needles and Syringes	Both	Hypodermic needles and syringes prescribed by a practitioner for administering medications.
<a href="#">38a-511</a> <a href="#">38a-550</a>	Imaging Services (MRIs, CAT scans, and PET scans) – Copays	Both	Limits copays for MRIs and CAT scans to (1) \$375 for all such services annually and (2) \$75 for each one. Limits copays for PET scans to (1) \$400 for all such scans annually and (2) \$100 for each one. Limits not applicable (1) if the ordering physician performs the service or is in the same practice group as the one who does and (2) to high deductible health plans designed to be compatible with federally qualified Health Savings Accounts.
<a href="#">38a-509</a> <a href="#">38a-536</a>	Infertility	Both	Medically necessary costs of diagnosing and treating infertility.
<a href="#">38a-498c</a> <a href="#">38a-525c</a>	Injured and Under the Influence	Both	Insurance policies prohibited from denying coverage for health care services rendered to an injured insured person if the injury is alleged to have occurred or occurs when the person has an elevated blood alcohol level (0.08% or more) or is under the influence of drugs or alcohol.
<a href="#">38a-535</a>	Lead Screening	Both	Coverage for blood lead screening and risk assessments ordered by primary care providers in accordance with the law.
<a href="#">38a-501</a>	Long-Term Care Policy – Elimination Period	Individual	Requires an elimination period (i.e., a waiting period after the onset of the injury, illness, or function loss during which no benefits are payable) that is (1) up to 100 days of confinement or (2) between 100 days and two years of confinement if an irrevocable trust is in place that is estimated to be sufficient to cover the person's confinement costs during this period. Sets requirements for the trust.
<a href="#">38a-501</a>	Long-Term Care Policy – Non-Forfeiture	Individual	Prohibits an insurer from issuing or delivering a long-term care policy on or after July 1, 2008 unless it had offered the prospective insured an optional non-forfeiture benefit during the policy solicitation or application process. If the non-forfeiture option is declined, the insurer must give the insured a contingent benefit upon lapse.
<a href="#">38a-492h</a> <a href="#">38a-518h</a>	Lyme Disease Treatment	Both	Lyme disease treatment including not less than 30 days of intravenous antibiotic therapy, 60 days of oral antibiotic therapy, or both, and further treatment if recommended by a rheumatologist, infectious disease specialist, or neurologist.
<a href="#">38a-503d</a> <a href="#">38a-530d</a>	Mastectomy	Both	Minimum 48-hour hospital stay after mastectomy or lymph node dissection or longer stay if recommended by physician.

Table 1 (continued)

CGS §	Mandate	Individual, Group, or Both	Description
<a href="#">38a-503c</a> <a href="#">38a-530c</a>	Maternity Care	Both	Minimum 48-hour hospital stay for mother and newborn after vaginal delivery and minimum 96-hour hospital stay after caesarian delivery.
<a href="#">38a-488a</a> <a href="#">38a-514</a>	Mental Illness	Both	<p>Diagnosis and treatment of mental or nervous conditions. Coverage cannot differ from the terms, conditions, or benefits for the diagnosis or treatment of medical, surgical, or other physical health conditions.</p> <p>Requires a policy to cover a residential treatment facility when a physician, psychiatrist, psychologist, or clinical social worker assesses the person and determines that he or she cannot appropriately, safely, or effectively be treated in another setting.</p>
<a href="#">38a-498b</a> <a href="#">38a-525b</a>	Mobile Field Hospitals	Both	Benefits for isolation care and emergency services provided by mobile field hospitals, previously called critical access hospitals. These benefits are subject to any policy provisions that apply to other covered services. The rates a policy pays must be equal to the rates Medicaid pays, as determined by the Department of Social Services.
<a href="#">38a-503b</a> <a href="#">38a-530b</a>	Obstetrician-Gynecologist; Pap Smear	Both	Direct access to participating in-network OB-GYN for gynecological examination, pregnancy care, and primary and preventive obstetric and gynecologic services required as result of a gynecological examination or condition (includes pap smear). Female enrollees may also designate participating OB-GYN or other doctor as primary care provider.
<a href="#">38a-496</a> <a href="#">38a-524</a>	Occupational Therapy	Both	If policy covers physical therapy, it must provide coverage for occupational therapy.
<a href="#">PA 14-97</a>	Occupational Therapy Services - Copays	Both	Effective January 1, 2015, cannot impose a copayment of more than \$30 per visit for in-network occupational therapy services performed by a state-licensed occupational therapist.
<a href="#">38a-492b</a> <a href="#">38a-518b</a>	Off-Label Cancer Drugs	Both	If a prescription drug is recognized for treatment of a specific type of cancer, a policy cannot exclude coverage of the drug when it is used for another type of cancer.
<a href="#">38a-504(d)</a> <a href="#">38a-542(d)</a>	Oral Chemotherapy	Both	Policies that cover intravenously and orally administered anti-cancer medications must cover the orally administered medication on at least as favorable a basis as the intravenously administered medication.
<a href="#">38a-492j</a> <a href="#">38a-518j</a>	Ostomy Appliances and Supplies	Both	If policy covers ostomy surgery, it must also cover medically necessary ostomy-related appliances and supplies, up to \$2,500 per year.
<a href="#">38a-492i</a> <a href="#">38a-518i</a>	Pain Management	Both	<p>Access to a pain management specialist and coverage for pain treatment ordered by such specialist.</p> <p>Cannot require an insured person to use an alternative brand name prescription or over-the-counter drug before using a brand name prescription drug prescribed by a licensed physician for pain management.</p>
<a href="#">38a-511a</a> <a href="#">38a-550a</a>  Pursuant to <a href="#">PA 13-307</a>	Physical Therapy Services – Copays	Both	Effective January 1, 2015, cannot impose a copayment of more than \$30 per visit for in-network physical therapy services performed by a state-licensed physical therapist.
<a href="#">38a-476(b)(1)</a>	Preexisting Condition Coverage	Group	May not impose preexisting condition exclusion beyond 12 months after effective date of coverage, and exclusion may relate only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received six months before the policy's effective date.
<a href="#">38a-476(g)</a>	Preexisting Condition Coverage	Individual short-term policy	May not impose preexisting condition exclusion beyond 12 months after effective date of coverage, and exclusion may relate only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received 24 months before the policy's effective date.
<a href="#">38a-476(b)(2)</a>	Preexisting Condition Coverage	Individual, except for short-term policy	May not impose preexisting condition exclusion beyond 12 months after effective date of coverage, and exclusion may relate only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received 12 months before the policy's effective date.

Table 1 (continued)

CGS §	Mandate	Individual, Group, or Both	Description
<a href="#">38a-492f</a> <a href="#">38a-518f</a>	Prescription Drugs Removed from Formulary	Both	A prescription drug that has been removed from the list of covered drugs must be continued if the insured was previously using the drug for the treatment of a chronic illness and it is deemed medically necessary.
<a href="#">38a-492m</a> <a href="#">38a-518l</a>	Prescription Eye Drops	Both	Policies that provide prescription eye drop coverage cannot deny coverage for prescription renewals when (1) the refill is requested by the insured person less than 30 days from either (a) the date the original prescription was given to the insured or (b) the last date the prescription refill was given to the insured, whichever is later, and (2) the prescribing physician indicates on the original prescription that additional quantities are needed and the refill request does not exceed this amount.
<a href="#">38a-510a</a> <a href="#">38a-544a</a>	Prescription Refills Synchronized	Both	Cannot deny coverage for refilling any drug prescribed to treat a chronic illness if the refill is made in accordance with a plan to synchronize the refilling of multiple prescriptions.
Pursuant to <a href="#">PA 13-131</a>			
<a href="#">38a-535</a>	Preventive Pediatric Care	Group	Preventive pediatric care at the following intervals (1) every 2 months from birth to 6 months, (2) every 3 months from 9 to 18 months, and (3) annually from 2 to 6 years of age. Coverage is subject to any policy provisions that apply to other services covered under the policy.
<a href="#">38a-492g</a> <a href="#">38a-518g</a>	Prostate Screening	Both	Laboratory and diagnostic tests to screen for prostate cancer for men who are symptomatic, have a family history, or are over age 50.  Policy must cover medically necessary prostate cancer treatment in accordance with guidelines established by the National Comprehensive Cancer Network, American Cancer Society, or American Society of Clinical Oncology.
<a href="#">38a-492c</a> <a href="#">38a-518c</a>	Protein Modified Food and Specialized Formula	Both	Amino acid modified and low protein modified food products when prescribed for the treatment of inherited metabolic diseases and cystic fibrosis. Medically necessary specialized formula for children up to age 12. Food and formula must be administered under the direction of a physician. Coverage for preparations, food products, and formulas must be on the same basis as coverage for outpatient prescription drugs.
<a href="#">38a-476b</a>	Psychotropic Drugs	Both	A mental health care benefit provided under state law, with state funds, or to state employees may not limit the availability of the most effective psychotropic drugs.
<a href="#">38a-523</a>	Rehabilitation Services	Group	Group health insurance must offer coverage for comprehensive rehabilitation services, including (1) physician services, physical and occupational therapy, nursing care, psychological and audiological services, and speech therapy; (2) social services provided by a social worker; (3) respiratory therapy; (4) prescription drugs and medicines; (5) prosthetic and orthotic devices; and (6) other supplies and services prescribed by a doctor.
<a href="#">38a-504(a)&amp;(b)</a> <a href="#">38a-542(a)&amp;(b)</a>	Treatment for Leukemia, Tumors, and Wigs for Chemotherapy Patients	Both	Surgical removal of tumors and treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, non-dental prosthesis, surgical removal of breasts due to tumors, and a wig if prescribed by a licensed oncologist for a patient suffering hair loss from chemotherapy. Annual coverage must be at least \$500 for surgical tumor removal, \$500 for reconstructive surgery, \$500 for outpatient chemotherapy, \$350 for a wig, and \$300 for prosthesis, except for surgical removal of breasts due to tumors, the prosthesis benefit must be at least \$300 for each breast removed.

\* Notes:

- Some mandates require that services be "medically necessary." State law specifies the definition of "medically necessary" that policies must include (see [CGS §§ 38a-482a](#) and [38a-513c](#)).
- Section 2711 of the federal Patient Protection and Affordable Care Act prohibits annual dollar limits on essential health benefits. The federal prohibition preempts Connecticut's statutory annual dollar limits for any mandated benefit that is part of Connecticut's essential health benefit package. For more information, see the Connecticut Insurance Department's Bulletins [HC-90-14-2](#) (March 18, 2014) and [HC-96](#) (April 22, 2014).

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