Office of Legislative Research
Research Report
December 22, 2015
2015-R-0272

OLR BACKGROUNDER: STATE-MANDATED HEALTH INSURANCE BENEFITS

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ISSUE

List and briefly describe Connecticut's mandated health insurance benefits.

This report updates OLR Report 2014-R-0143 by incorporating laws enacted in 2015. See OLR Report 2015-R-0273 for a list of health care providers and facilities whose services health insurance policies and HMO contracts must cover under state law.

SUMMARY

A health insurance benefit mandate is a requirement that an insurance policy 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 health plans to which the mandate applies. Most of the mandates apply to both individual and group health insurance plans, including HMO contracts. However, due to the federal Employee Retirement Income Security Act (ERISA), state benefit mandates generally do not apply to self-funded health plans. For a discussion of this ERISA preemption, see OLR Report 2005-R-0753.

In 2015, the legislature enacted the following four acts that include provisions related to health insurance benefit mandates:

1. PA 15-88 (§§ 2 & 3), An Act Concerning the Facilitation of Telehealth (effective January 1, 2016).
2. PA 15-226, An Act Concerning Health Insurance Coverage for Mental or Nervous Conditions (effective January 1, 2016).
3. PA 15-247 (§ 8, concerning preexisting condition coverage), An Act Concerning Revisions to the Health Insurance Statutes (effective upon passage, July 10, 2015).

4. PA 15-5, June Special Session ((§§ 347-353, concerning coverage for autism spectrum disorder treatment and birth-to-three services, and §§ 469 & 470, concerning coverage for off-label prescription drugs), An Act Implementing Provisions of the State Budget for the Biennium Ending June 30, 2017, Concerning General Government, Education, Health and Human Services and Bonds of the State (effective January 1, 2016).

For a discussion of when the state must defray the cost of health insurance benefit mandates under the federal Patient Protection and Affordable Care Act (ACA), see OLR Report 2015-R-0188.

CONNECTICUT'S MANDATED HEALTH INSURANCE BENEFITS

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

Table 1: Connecticut's Mandated Health Insurance Benefits*

CGS §	*Mandate*	*Individual, Group, or Both*	*Description*
38a-498a 38a-525a	911 Calls	Both	Cannot require preauthorization for 911 calls.
38a-492 38a-518	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.
38a-533	Alcoholism	Group	Expenses incurred in connection with medical complications of alcoholism such as cirrhosis of the liver, gastrointestinal bleeding, pneumonia, and delirium tremens.
38a-498 38a-525	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.
38a-514b 38a-488b	Autism Spectrum Disorder	Both	Policies must cover the diagnosis and treatment of autism spectrum disorders, including (1) behavioral therapy for a person age 20 or younger and (2) certain prescription drugs and psychiatric and psychological services.
38a-516a 38a-490a	Birth-to-Three Services	Both	Policies cannot impose coinsurance, copayments, deductibles, or other out-of-pocket expenses for early intervention services, unless it is a high deductible health plan used to establish a medical savings account.
38a-492o 38a-518o	Bone Marrow Testing	Both	Policies must cover compatibility testing for bone marrow transplants for people who join the National Marrow Donor Program.
38a-503 38a-530	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. 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 American Cancer Society guidelines.

CGS §	Mandate	Individual, Group, or Both	Description
38a-542(a)&(b)	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.
38a-504(c) 38a-542(c)	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.
38a-504a – 38a-504g; 38a-542a – 38a-542g	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.
38a-482 38a-497	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.
38a-489 38a-515 38a-554	Children - Mentally or Physically Handicapped	Both	After passing dependent status age when coverage would otherwise end, coverage must continue if the child is both mentally or physically handicapped and dependent upon insured for support.
38a-490 38a-508 38a-516 38a-549	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.
38a-497 38a-554	Children - Stepchildren	Both	Policies must cover stepchildren on the same basis as biological children.
38a-492l 38a-516d	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.
38a-507 38a-534	Chiropractic Services	Both	Cover chiropractor services to same extent as coverage for a physician.
38a-492k 38a-518k	Colorectal Cancer Screening	Both	Coverage for colorectal cancer screening. Frequency of screening must be based on American Cancer Society recommendations. 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 was used to establish a medical savings account. Cannot impose a deductible for a procedure initially undertaken as a screening colonoscopy or screening sigmoidoscopy.
38a-503e 38a-530e	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.
38a-490c 38a-516c	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.
38a-491a 38a-517a	Dental Coverage	Both	Medically necessary general anesthesia, nursing, and related hospital services for in-patient, outpatient, or one-day dental services.
38a-492d 38a-518d	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.
38a-492e 38a-518e	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.
38a-492n 38a-518m	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.

CGS §	Mandate	Individual, Group, or Both	Description
38a-483c 38a-513b	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.
38a-490b 38a-516b	Hearing Aids	Both	Coverage for hearing aids. Coverage may be limited to $1,000 within a 24-month period. (See Insurance Department Bulletin HC-102 for discussion.)
38a-493 38a-520	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.
38a-492a 38a-518a	Hypodermic Needles and Syringes	Both	Hypodermic needles and syringes prescribed by a practitioner for administering medications.
38a-511 38a-550	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.
38a-509 38a-536	Infertility	Both	Medically necessary costs of diagnosing and treating infertility. (See Insurance Department Bulletin HC-104 for discussion.)
38a-498c 38a-525c	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.
38a-535	Lead Screening	Both	Coverage for blood lead screening and risk assessments ordered by primary care providers in accordance with the law.
38a-501	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.
38a-501	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.
38a-492h 38a-518h	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.
38a-503d 38a-530d	Mastectomy	Both	Minimum 48-hour hospital stay after mastectomy or lymph node dissection or longer stay if recommended by physician.
38a-503c 38a-530c	Maternity Care	Both	Minimum 48-hour hospital stay for mother and newborn after vaginal delivery and minimum 96-hour hospital stay after caesarian delivery.
38a-488a 38a-514	Mental Illness	Both	Diagnosis and treatment of mental or nervous conditions. Coverage cannot (1) differ from the terms, conditions, or benefits for the diagnosis or treatment of medical, surgical, or other physical health conditions or (2) prohibit multiple screening services as part of a single-day visit to a provider or multicare institution.
38a-498b 38a-525b	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.

CGS §	Mandate	Individual, Group, or Both	Description
38a-503b 38a-530b	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.
38a-496 38a-524	Occupational Therapy	Both	If policy covers physical therapy, it must provide coverage for occupational therapy.
38a-511a 38a-550a	Occupational Therapy Services - Copays	Both	A policy cannot impose a copayment of more than $30 per visit for in-network occupational therapy services performed by a state-licensed occupational therapist.
38a-492b 38a-518b	Off-Label Prescription Drugs	Both	If a prescription drug is recognized for treatment of a specific type of cancer or disabling or life threatening chronic disease, a policy cannot exclude coverage of the drug when it is used for another type of cancer or disease under certain circumstances.
38a-504(d) 38a-542(d)	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.
38a-492j 38a-518j	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.
38a-492i 38a-518i	Pain Management	Both	Access to a pain management specialist and coverage for pain treatment ordered by such specialist. 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.
38a-511a 38a-550a	Physical Therapy Services – Copays	Both	A policy cannot impose a copayment of more than $30 per visit for in-network physical therapy services performed by a state-licensed physical therapist.
38a-476(b)(1)	Preexisting Condition Coverage	Group	May not impose preexisting condition exclusion on any person.
38a-476(c)	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.
38a-476(b)(2)	Preexisting Condition Coverage	Individual, except for short-term policy	May not impose preexisting condition exclusion on any person.
38a-492f 38a-518f	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.
38a-492m 38a-518l	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.
38a-510a 38a-544a	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.
38a-535	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.

CGS §	Mandate	Individual, Group, or Both	Description
38a-492g 38a-518g	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 National Comprehensive Cancer Network, American Cancer Society, or American Society of Clinical Oncology guidelines.
38a-492c 38a-518c	Protein Modified Food and Specialized Formula	Both	Coverage for (1) amino acid modified and low protein modified food products when prescribed for the treatment of inherited metabolic diseases and cystic fibrosis and (2) 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.
38a-476b	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.
38a-523	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.
PA 15-88	Telehealth	Both	Policies must cover medical advice, diagnosis, care, or treatment provided through telehealth to the extent that they cover these services through in-person visits between an insured person and a health care provider.
38a-504(a)&(b) 38a-542(a)&(b)	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:

1. 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).

2. Section 2711 of the ACA prohibits annual dollar limits on essential health benefits. The 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).

3. Section 1557 of the ACA prohibits discrimination in benefit design based on age. Age-based restrictions for hearing aids and infertility treatment are not permitted. For more information, see the Connecticut Insurance Department's Bulletins HC-102 (June 15, 2015) and HC-104 (August 13, 2015).

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