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ResearchReport

OLR Backgrounder: State-Mandated Health Insurance Benefits

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Issue

This report lists and briefly summarizes Connecticut's mandated health insurance benefits. This report has been updated by OLR Report 2021-R-0218.

Summary

A mandated health insurance benefit is a requirement that a fully-insured commercial health insurance policy or plan cover a specified benefit or service.

In Connecticut, mandated health insurance benefits are contained in Chapter 700c of the General Statutes. Most mandates apply to both individual and group health insurance policies, including HMO plans. However, due to the federal Employee Retirement Income Security Act (ERISA), state benefit mandates generally do not apply to self-funded health plans.

Related OLR Reports

OLR Report 2015-R-0273 provides a list of health care providers and facilities whose services health insurance policies and HMO contracts must cover under state law (i.e., provider and facility mandates).

OLR Report 2015-R-0188 discusses when the state must defray the cost of health insurance benefit mandates under the federal Affordable Care Act.

OLR Report 2020-R-0214 explains federal preemption of state benefit mandates under ERISA.

In 2020, the legislature enacted two acts affecting health insurance benefit mandates, as follows: (1) diabetes screening, drugs, and devices, including emergency insulin and supplies (PA 20-4, July Special Session (JSS), §§ 13 & 14) and (2) telehealth (PA 20-2, JSS, §§ 3-5).

Connecticut's Mandated Health Insurance Benefits

Table 1 lists and briefly summarizes Connecticut's mandated health insurance benefits in alphabetical order. It provides the statutory citation for each and indicates if the mandate generally applies to individual plans, group plans, or both. For full details of a mandated benefit, refer to the cited statute(s).

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 complications	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	Medically necessary ambulance services. Payment must be on a direct pay basis where notice of assignment is reflected on the bill.
38a-488b 38a-514b	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-490a 38a-516a	Birth-to-Three Services	Both	Early intervention services provided as part of an individualized family service plan. Policy cannot impose coinsurance, copayments, deductibles, or other out-of-pocket expenses, unless it is a high deductible health plan (HDHP).
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. Policy cannot impose coinsurance, copayments, deductibles, or other out-of-pocket expenses in excess of 20%, unless a HDHP.

Table 1 (continued)

CGS §	Mandate	Individual, Group, or Both	Description
38a-503 38a-530	Breast Cancer Screening	Both	Baseline mammogram for a woman age 35 to 39 and one mammogram every year for a woman age 40 and older. A mammogram may be provided by breast tomosynthesis at the woman's option. Additional coverage must be provided for a comprehensive ultrasound screening of a woman's entire breast(s) if (1) she has heterogeneous or dense breast tissue; (2) there is an increased breast cancer risk because of family history, her prior history, genetic testing, or other indications ;or (3) it is recommended by a physician and she is age 40 or older, has a family or personal history of breast cancer, or a personal history of benign breast disease. Coverage must be provided for magnetic resonance imaging (MRI) in accordance with American Cancer Society guidelines. Policy cannot impose a coinsurance, copayment, deductible, or other out-of-pocket expense for these benefits, unless it is a HDHP.
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.
38a-497 38a-512b	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	Children – Mentally or Physically Handicapped	Both	Coverage must continue beyond the dependent age if the child is both mentally or physically handicapped and dependent upon the 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-512b	Children – Stepchildren	Both	Policies must cover stepchildren on the same basis as biological children.

Table 1 (continued)

CGS §	Mandate	Individual, Group, or Both	Description
38a-492*l* 38a-516d	Children with Cancer – Neurological Testing	Both	Coverage for neuropsychological testing a physician orders to assess if chemotherapy or radiation treatment caused 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	Cover colorectal cancer screening in accordance with 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, excluding HDHPs. Cannot impose a deductible for a procedure initially undertaken as a screening colonoscopy or screening sigmoidoscopy.
38a-503e 38a-530e	Contraceptive Benefits, Sterilization and Related Services	Both	Policies must cover FDA-approved contraceptive drugs, devices, and products; sterilization methods for women; routine follow-up care; and related counseling. Policies must cover a 12-month supply of an FDA-approved contraceptive drug, device, or product prescribed by a licensed physician, physician assistant, or advanced practice registered nurse. An employer or individual may decline coverage for contraceptive benefits and services if contrary to their bona fide religious tenets. Such coverage must be provided in full, with no cost sharing, except policies may impose cost sharing when an out-of-network provider renders the benefits and services.
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 for cosmetic surgery is not required.
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	Effective until December 31, 2021. 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.
PA 20-4, JSS, §§ 13 & 14	Diabetes	Both	Effective January 1, 2022. Treatment of all types of diabetes, including coverage for medically necessary laboratory and diagnostic testing and screening, insulin drugs, noninsulin drugs, diabetes devices, diabetes ketoacidosis devices, and certain emergency insulin and supplies. Cannot impose coinsurance, copays, deductibles, or out-of-pocket expenses that are more than the following: (1) $25 for a 30-day supply of insulin or noninsulin drugs and (2) $100 for a 30-day supply of diabetes devices or diabetes ketoacidosis devices (generally excludes HDHPs).

Table 1 (continued)

CGS §	Mandate	Individual, Group, or Both	Description
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-478r	Emergency Medical Conditions	Both	Policies must cover medically necessary health care services for emergency medical conditions.
38a-477aa	Emergency Services	Both	Cannot require preauthorization for emergency services.
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.
38a-492q 38a-492r 38a-492s 38a-503f 38a-530f 38a-518q 38a-518r 38a-518s	Essential Health Benefits and Preventive Health Services, including Immunizations	Individual and Small Employer Group Plans	Policies must cover the following 10 essential health benefits and cannot include annual or lifetime limits on their dollar value: ambulatory patient services, emergency services, hospitalization, maternity and newborn health care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services, and pediatric services. Policies must also cover (1) specified preventive health care services, including evidence-based items and services recommended by the U.S. Preventive Services Task Force with an "A" or "B" rating, (2) immunizations recommended by specified sources, and (3) pediatric preventive care and screenings in accordance with the American Academy of Pediatrics recommendations. Such coverage must be provided in full, with no cost sharing, except policies may impose cost sharing when an out-of-network provider renders the benefits and services.
38a-483c 38a-513b	Experimental Treatments	Both	Procedures, treatments, or drugs that have completed a Phase III Food and Drug Administration clinical trial.
38a-490b 38a-516b	Hearing Aids	Both	Coverage for hearing aids. Coverage may be limited to one hearing aid per ear within a 24-month period.
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 provision covering at least 75%, excluding HDHPs.
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 HDHPs.
38a-509 38a-536	Infertility	Both	Medically necessary costs of diagnosing and treating infertility. (See Insurance Department Bulletin HC-104 discussion.)

Table 1 (continued)

CGS §	Mandate	Individual, Group, or Both	Description
38a-498c 38a-525c	Injured and Under the Influence	Both	Policies are prohibited from denying coverage for health care services 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-490d 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 sufficient to cover the person's confinement costs during this period. Establishes trust requirements.
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 offers the prospective insured an optional non-forfeiture benefit. 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. If discharged earlier, policy must cover certain follow up care.
38a-488c 38a-514c	Mental Health and Substance Use Disorders	Both	Policies cannot apply non-quantitative treatment limitations (i.e., non-numeric limits on the scope or duration of coverage, such as prior authorization requirements) to mental health and substance use disorder benefits unless they apply the limitations comparably to, and not more stringently than, how it applies them to medical and surgical benefits.
38a-488a 38a-514	Mental or Nervous Conditions	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 multi-care 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.
38a-503c(e) 38a-530c(e)	Newborn Infants and Their Mothers	Both	Cannot require preauthorization for an inter-hospital transfer of (1) a newborn infant with a life-threatening emergency or condition or (2) the infant's hospitalized mother to accompany him or her.

Table 1 (continued)

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	Preexisting Condition Coverage	Both	May not impose preexisting condition provision on any person.
38a-492f 38a-518f	Prescription Drugs Removed from Formulary	Both	Coverage for 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-518*l*	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 notes that additional quantities are needed and the refill request does not exceed this amount.
38a-510b 38a-544b	Prescription Opioid Antagonists	Both	Cannot require preauthorization for naloxone hydrochloride or any other similarly acting and equally safe drug (i.e., opioid antagonist) approved by the federal Food and Drug Administration for the treatment of drug overdose.

Table 1 (continued)

CGS §	Mandate	Individual, Group, or Both	Description
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.
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-492t 38a-518t	Prosthetic Devices	Both	Policies must cover prosthetic devices, and medically necessary repairs and replacements to them, subject to specified conditions. Coverage must be at least equivalent to the coverage Medicare provides for such devices.
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	Insurers providing 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 prescribed supplies and services.
38a-488d 38a-514d	Substance Abuse Services – Court Ordered	Both	Cannot deny covered substance abuse services solely because they are court ordered.
38a-492p 38a-518p	Substance Use Disorder – Inpatient Detoxification Services	Both	For insureds or enrollees diagnosed with a substance use disorder, policies must cover medically necessary (1) medically monitored inpatient detoxification services and (2) medically managed intensive inpatient detoxification services.
38a-499a 38a-526a	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.

Table 1 (continued)

CGS §	Mandate	Individual, Group, or Both	Description
PA 20-2, JSS, §§ 3-5 as amended by PA 20-4, JSS	Telehealth (expanded)	Both	Effective July 31, 2020, to March 15, 2021. Policies must cover services provided through telehealth to the extent that they cover them through in person visits. Carriers cannot (1) exclude coverage for a telehealth platform selected by an in-network provider or (2) reduce reimbursement to a provider because services are provided through telehealth instead of in person.
38a-504(a)&(b) 38a-542(a)&(b)	Tumors and Leukemia 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-99 (August 20, 2014).

3. Section 1557 of the ACA prohibits discrimination in benefit design based on age. For example, age-based restrictions for infertility treatment are not permitted. For more information, see the Connecticut Insurance Department’s Bulletin HC-104 (August 13, 2015).

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