OLR RESEARCH REPORT

December 4, 2007 2007-R-0703

MANDATED BENEFITS FOR INSURANCE POLICIES

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You asked for a list benefits that Connecticut law requires health care insurance policies to include.

In Connecticut, health insurance mandates are contained in Chapter 700c of the general statutes. Each benefit mandate statute identifies the plans to which it applies. Many apply to both individual and group health insurance policies, including those insured plans issued to small employer groups. However, in general, state benefit mandates do not apply to self-insured plans due to federal preemption.

Table 1 provides a list of Connecticut's mandated benefits.

Also, enclosed is document that the Council for Affordable Health Insurance (CAHI), an insurance research and advocacy association, published. It includes a chart of health insurance mandates by state, and is online at: http://www.cahi.org/cahi_contents/resources/pdf/MandatesInTheStates2007.pdf.

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Table 1: Connecticut Health Care Insurance Mandated Benefits

CGS §	*Mandate*	*Applicable to Group Policy, Individual Policy, or Both*	*Description*
38a-476(b)(1)	Preexisting Condition Coverage	Group	May not impose preexisting condition exclusion beyond 12 months after effective date of coverage, and exclusion may only relate to conditions for which medical advice, diagnosis, care, or treatment was recommended or received six months before the policy's effective date.
38a-476(b)(2) PA 07-113 amended	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 only relate to conditions for which medical advice, diagnosis, care, or treatment was recommended or received 12 months before the policy's effective date.
38a-476(g) PA 07-113 amended	Preexisting Condition Coverage	Individual short-term policy	May not impose preexisting condition exclusion beyond 12 months after effective date of coverage, and exclusion may only relate to conditions for which medical advice, diagnosis, care, or treatment was recommended or received 24 months before the policy's effective date.
38a-476b	Availability of Psychotropic Drugs	Both	No mental health care benefit provided under state law, or with state funds or to state employees may limit the availability of the most effective psychotropic drugs.
38a-483c 38a-513b	Experimental Treatments	Both	Procedures, treatments, or drugs that have completed a Phase III FDA clinical trial. Appeals process expedited for those with a life expectancy of less than two years.
38a-488a 38a-514	Mental Illness Parity	Both	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.
38a-489 38a-515	Mentally or Physically Handicapped Dependent Children	Both	After passing dependent status and coverage would otherwise end, coverage must continue if child is both mentally or physically handicapped and dependent upon insured for support.
38a-490 38a-508 38a-516 38a-549	Newborns and Adopted Children	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.

Table 1: -Continued-

CGS §	***Mandate***	***Applicable to Group Policy, Individual Policy, or Both***	***Description***
38a-490a 38a-516a	Birth-to-Three	Both	At least $3,200 per child annually for medically necessary early invention services, up to $9,600 per child over three years.
38a-490b 38a-516b	Hearing Aids for Children	Both	Hearing aids for children 12 and under. Coverage may be limited to $1,000 within a 24-month period.
38a-490c 38a-516c	Craniofacial Disorders	Both	Medically necessary orthodontic processes and appliances for treatment of craniofacial disorders for people under age 18. Coverage is not required for cosmetic surgery.
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-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-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-492a 38a-518a	Hypodermic Needles and Syringes	Both	Hypodermic needles and syringes prescribed by a prescribing practitioner for administering medications.
38a-492b 38a-518b	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.
38a-492c 38a-518c PA 07-197 amended	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 outpatient prescription drugs.

Table 1: -Continued-

CGS §	***Mandate***	***Applicable to Group Policy, Individual Policy, or Both***	***Description***
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-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-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 50.
38a-492h 38a-518h	Lyme Disease Treatment	Both	Lyme disease treatment including not less that 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-492i 38a-518i	Pain Management	Both	Access to a pain management specialist and coverage for pain treatment ordered by such specialist.
38a-492j 38a-518j	Ostomy Appliances and Supplies	Both	If policy covers ostomy surgery, policy must also cover up to $1000 per year for medically necessary ostomy-related appliances and supplies.
38a-492k 38a-518k	Colorectal Cancer Screening	Both	Colorectal cancer screening. Frequency of screening to be based on recommendations by the American College of Gastroenterology.

Table 1: -Continued-

CGS §	***Mandate***	***Applicable to Group Policy, Individual Policy, or Both***	***Description***
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 no more than $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-523	Comprehensive 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.
38a-496 38a-524	Occupational Therapy	Both	If policy covers physical therapy, it must provide coverage for occupational therapy.
38a-482 38a-497 38a-554 PA 07-185 (§§ 15-17), amended by PA 07-2, JSS (§§ 64, 65, & 69)	Dependant Children	Both	Effective January 1, 2009: Extends, from age 19 and 23 to 26, the age to which policies that cover children must do so. The act eliminates the requirements that children be dependent or full-time students.
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-498a 38a-525a	911 Calls	Both	Cannot require preauthorization for 911 calls.

Table 1: -Continued-

CGS §	***Mandate***	***Applicable to Group Policy, Individual Policy, or Both***	***Description***
38a-498b 38a-525b PA 07-252 (§§ 68-71) amended	Mobile Field Hospitals	Both	Benefits for isolation care and emergency services provided by mobile field hospitals, previously called critical access hospitals. Such 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-498c 38a-525c	Injured and Under the Influence	Both	Insurance polices 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-501 PA 07-28 amended	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-501 PA 07-226 amended	Long-Term Care Policy – Elimination Period	Individual	Changes the elimination period required under a long-term care insurance policy. Prior law required a "reasonable" elimination period (i.e., a waiting period after the onset of the injury, illness, or function loss during which no benefits are payable). The act instead requires an elimination period 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-502 38a-529	Veteran's Home and Hospital	Both	Cannot exclude coverage for services provided by the Veteran's Home and Hospital.

Table 1: -Continued-

CGS §	***Mandate***	***Applicable to Group Policy, Individual Policy, or Both***	***Description***
38a-503 38a-530	Mammography and Breast Cancer Screening	Both	Baseline mammogram for woman 35 to 39 and one every year for woman 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) she 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.
38a-503b 38a-530b	Obstetrician-Gynecologist; Pap Smear	Both	Direct access to participating in-network ob-gyn for gynecological examination, care related to pregnancy, 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-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-503d 38a-530d	Mastectomy	Both	Minimum 48-hour hospital stay after mastectomy or lymph node dissection or longer stay if recommended by physician.
38a-503e 38a-530e	Contraceptives	Both	If prescription drugs are covered, then prescription contraceptives must be covered. An employer or individual may decline contraceptive coverage if it conflicts with religious beliefs.
38a-533	Treatment of Alcoholism	Group	Expenses incurred in connection with medical complications of alcoholism such as cirrhosis of the liver, gastrointestinal bleeding, pneumonia, and delirium tremens.
38a-507 38a-534	Chiropractic Services	Both	Cover chiropractor services to same extent as coverage for a physician.
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.

Table 1: -Continued-

CGS §	***Mandate***	***Applicable to Group Policy, Individual Policy, or Both***	***Description***
38a-535 PA 07-2, JSS (§§ 51 & 52)	Lead Screening	Both	Effective January 1, 2009: Coverage for blood lead screening and risk assessments ordered by primary care providers in accordance with § 48 of the act.
38a-509 38a-536	Infertility	Both	Medically necessary costs of diagnosing and treating infertility.
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 for removal of any such breast implant.
38a-504(a)&(b) 38a-542(a)&(b)	Treatment for Leukemia, Tumors, and Wigs for Chemotherapy Patients	Both	Surgical removal of tumors an 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 due to 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.
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 PA 07-67 amended	Cancer Clinical Trials	Both	Routine patient costs relating to cancer clinical trials. 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.

Table 1: -Continued-

CGS §	***Mandate***	***Applicable to Group Policy, Individual Policy, or Both***	***Description***
38a-511 38a-550	Copays for Imaging Services (MRIs, CAT scans, and PET scans)	Both	Limits copays for MRIs and CAT scans to no more than (1) $375 for all such services annually and (2) $75 for each one. Limits copays for PET scans to no more than (1) $400 for all such scans annually and (2) $100 for each one. Limits not applicable if (1) 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 compatible with federally qualified Health Savings Accounts.
PA 07-75	Medically Necessary Definition	Both	Specifies the definition of "medically necessary" that policies must include.

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