General Overview

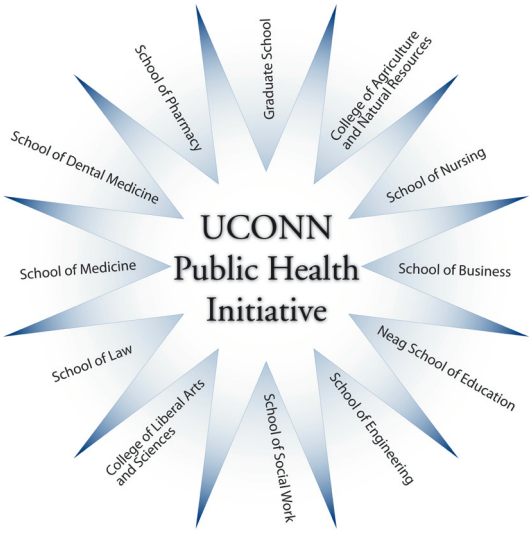
Connecticut Mandated Health Insurance Benefits

Reviews

2010

University of Connecticut

Center for Public Health and Health Policy



The Center for Public Health and Health Policy, a research and programmatic center founded in 2004, integrates public health knowledge across the University of Connecticut campuses and leads initiatives in public health research, health policy research, health data analysis, health information technology, community engagement, service learning, and selected referral services.

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Table of Contents

Connecticut Mandated Health Insurance Benefits Reviews
2010
Executive Summary

The Connecticut General Assembly, in Public Act 09-179, directed the Connecticut Insurance Department (Department) to review and evaluate all mandated health insurance benefits in effect in Connecticut as of January 1, 2009. It also directed the Department to contract with the University of Connecticut Center for Public Health and Health Policy (Center) to perform the review and evaluation. The Center reviewed forty-five health insurance benefit mandates that met the statutory definition in P.A. 09-179. The findings of these reviews are contained in Volumes I through IV of this report. These reviews should be read in conjunction with the reports of the consulting actuarial firm, Ingenix Consulting, that are attached to the General Overview and to each volume.

The statutory citation, brief description and effective dates, and the volume in which the review on each mandate is found are shown in Tables 1 and 2 of the General Overview, and the impact on premium of each mandate is shown in Table 3, below. The estimated medical cost, retention cost (administrative costs plus profit) and cost-sharing of each mandate are shown in Appendices One (group coverage) and Three (individual coverage) of the Ingenix Consulting Summary Report, attached to the General Overview as Appendix II. The percentages of members of self-funded plans who have equivalent benefits are shown for each mandate in Appendix Five of the Ingenix Consulting Summary Report.

The health insurance benefit mandates in effect in Connecticut on January 1, 2009 account for roughly 22 percent of total premium for group coverage and 18 percent of total premium for individual coverage. Five mandates (tumors and leukemia, mental health, psychotropic drugs, diabetes diagnosis and treatment, and newborn coverage) account for 12 percent of premium for group coverage. The next five highest mandates in terms of premium impact (colorectal cancer screening, off-label use of cancer drugs, infertility, mammography and chiropractors) account for five percent of total premium for group coverage.

The remaining 35 mandates account for five percent of group premium. Several of the remaining mandates have little or no impact on premiums, either because the services they mandate are very low cost or because they are accessed by a very small number of members, or both. Some high-cost services are accessed by such a small percentage of the members that the overall impact on premium is relatively small. Some of the mandates specify minimum dollar amounts of coverage that have been far outstripped by medical inflation since the mandates were enacted. As a result, these mandates have limited impact on premium.

The total estimated cost to the State plans for these mandates is $129,699,193. The State plan estimates for each mandate are shown in Appendix Four, column four of the Ingenix Consulting Summary Report. The estimated cost to the State plans includes a calculation for those members in retiree plans who do not participate in Medicare. It should be noted that this estimated cost is calculated using weighted averages for all claims paid by Connecticut-domiciled insurers and health maintenance organizations in the State. The actual cost of these mandates to the State plans may be higher or lower, based on the actual benefit design of the State plans and the demographics of the covered lives (e.g., level of cost-sharing, average age of members, etc.).

These reviews do not attempt to assess the impact of the recently enacted federal Patient Protection and Affordable Care Act, since that was beyond the scope of P.A. 09-179. However, the reviews may provide useful information to Connecticut policymakers as they begin to plan for implementation of the federal health care reform.

Connecticut Mandated Health Insurance Benefits Reviews 2010

General Overview

Introduction

In June 2009, the Connecticut General Assembly enacted P.A. 09-179, which, in part, directs the Connecticut Insurance Department (CID) to evaluate health insurance benefits mandated to be included in fully-insured group and individual health insurance policies issued, delivered or amended in Connecticut as of January 1, 2009. The statute sets out 25 criteria to be addressed in the evaluations of each mandated benefit. The criteria are divided into the social and the financial impacts of the mandates. This legislation is similar in some respects to that enacted in 30 other states.

Public Act 09-179 directs the CID to contract with the University of Connecticut Center for Public Health and Health Policy (CPHHP) to perform the reviews and authorizes the CID to assess the costs of the review to the insurance companies and managed care organizations doing business in Connecticut. It also authorizes the CID and the University to contract for whatever outside services may be needed to complete the evaluations. P.A. 09-179 is included with this introduction as Appendix I.

The CID entered into a Memorandum of Agreement with the University of Connecticut to utilize the services of the CPHHP in August 2009 to complete the reviews as described in the statute. CID also contracted with Ingenix Consulting (IC) of Rocky Hill, Connecticut to perform actuarial and economic analyses for the reviews. This contract was issued pursuant to a competitive bidding process completed in 2009 that also included the provision of actuarial services for the evaluation of seven proposed mandates for the Insurance and Real Estate Committee in the fall of 2009, pursuant to subsection (a) of P.A. 09-179.

Mandate identification

The CPHHP formed a working group of CPHHP researchers, CID actuarial and legal personnel and IC representatives to identify and evaluate the health insurance mandates that met the definition of "mandated benefit" included in P.A. 09-179. Section 1(a)(2) of that act defines "mandated benefit" as follows:

"Mandated health benefit" means an existing statutory obligation of, or proposed legislation that would require, an insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that offers individual or group health insurance or medical or health care benefits plan in this state to:

(A) permit an insured or enrollee to obtain health care treatment or services from a particular type of health care provider;

(B) offer or provide coverage for the screening, diagnosis or treatment of a particular disease or

condition; or

(C) offer or provide coverage for a particular type of health care treatment or service, or for medical equipment, medical supplies or drugs used in connection with a health care treatment or service.

"Mandated health benefit" includes any proposed legislation to expand or repeal an existing statutory obligation relating to health insurance coverage or medical benefits.

(P.A. 09-179, eff. July 1, 2009)

Forty-five existing health insurance mandates meet this definition and were in effect on January 1, 2009. Most of them apply to both individual and group policies; however, a few apply only to group or only to individual policies. Mandates which regulate underwriting policies or financial or reporting requirements of insurers were not included in this study because they fall outside the definition of "Mandated health benefit" in P.A. 09-179.

Review organization

For purposes of organization and work flow, the work group divided the 45 mandates into four groups. Claims data requests to insurers and managed care organizations (MCOs) were based on these groupings, as are the IC actuarial reports. For ease of reference, this study is organized into four volumes, one for each group of mandates, and this General Overview.

The General Overview includes a discussion of the process developed to carry out the mandate reviews and the major findings on all existing mandates. It also includes a listing of all the mandates, with statutory reference, title and volume in which the review of each is found (Tables 1 and 2). The Ingenix Consulting Summary Report of its actuarial findings is attached to this General Overview as Appendix II.

Volume I includes an introduction to eleven mandates that require health insurers and health care plans to cover specific diseases or conditions and the individual reviews for those mandates. The Ingenix Consulting report that covers set one is attached as an appendix to Volume I.

Volume II includes an introduction to eleven mandates that cover services to certain populations, i.e., women's and children's services and the individual reviews for those mandates. The Ingenix Consulting report that covers set two is attached as an appendix to Volume II.

Volume III includes an introduction to ten mandates that cover mental health and substance abuse services and the services of specific types of health care providers and the individual reviews for those mandates. The Ingenix Consulting report that covers set three is attached as an appendix to Volume III.

Volume IV includes an introduction to thirteen mandates for which there was limited claims data available, as well as miscellaneous mandates that were not included in the other groups, along with the individual reviews for those mandates. The Ingenix Consulting report that covers set four is attached as an appendix to Volume IV.

Each mandate review is written as a stand alone chapter, with all the information on that mandate contained within it. They are meant to be read in conjunction with the Ingenix Consulting Actuarial Report for the respective volume and the Ingenix Consulting Summary Report, which is attached to this General Overview as an appendix.

Claims data

With the assistance of the CID, the working group developed a format for requesting claims data from the six insurers/managed care organizations (MCOs) domiciled in Connecticut and subject to CID regulation. These insurers/MCOs account for approximately 90 percent of the Connecticut population covered by fully insured health insurance policies issued in Connecticut. The working group requested claims data related to each mandated benefit for calendar years 2007 and 2008 for both individual policies and group contracts from each insurer/MCO. In addition, Ingenix Consulting reviewed claims data in its own proprietary databases as a comparison for and to augment the claims data submitted by the carriers.

The insurers/MCOs submitted both total cost data and data on a per member per month (PMPM) basis, which is the common practice for purposes of reporting costs in the health insurance industry. The "per member" refers to all lives covered by the health insurance policy. This includes the insured and any family members or other persons included in the insured's coverage. Most cost and financial impact data in the study are reported on a PMPM basis.

Research methods

Under the direction of CPHHP, medical librarians at the Lyman Maynard Stowe Library at the University of Connecticut Health Center (UCHC) gathered published articles and other information related to medical, social, economic, and financial aspects of the required benefit. CPHHP staff also conducted independent literature searches using similar search terms to those used by the UCHC medical librarians. Where available, articles published in peer-reviewed journals are cited to support the analyses.

In addition, CPHHP staff consulted with faculty from the University of Connecticut and University of Connecticut Health Center, as well as with community providers, on matters pertaining to medical standards of care; traditional, current and emerging practices; and evidence-based medicine related to the benefits. Staff gathered additional information through telephone and e-mail inquiries to appropriate state, federal, municipal, and non-profit entities and from internet sources such as the State of Connecticut website, Centers for Medicare and Medicaid (CMS) website, the websites of the Centers for Disease Control and Prevention and the National Institutes of Health, other states' websites, the National Council of State Legislatures website, professional organizations' websites, and non-profit and community-based organization websites.

Each review is based on this research and the actuarial and economic analysis provided by Ingenix Consulting.

General discussion

The amount of information available varied tremendously among the mandates. Some mandates are common throughout the states. Others are found only in Connecticut or a few other states. In some cases the language is somewhat standardized among the states. In others, the language, the covered services and/or the dollar amounts vary widely. Some conditions have been researched extensively, both the medical science and the economic impact. Others have relatively little research associated with them. The reviews strive to give an accurate reflection of the available data and research on each mandate.

These reviews are a retrospective review of the existing Connecticut health insurance benefit mandates as of January 1, 2009. (Mandates which were not effective as of that date are not included, pursuant to P.A. 09-179.) As the Ingenix Consulting Summary Report points out, these reviews are not an evaluation of

the value or utility of any of these mandates. Each review is an objective review of the medical science and standard of care associated with the mandated service, the estimated cost and impact on insurance premiums of the mandate, and the social and financial impacts of the mandate.

It is important to keep in mind that state health insurance benefit mandates only apply to fully insured health insurance policies and plans. They are not applicable to self-funded plans, which are governed by the federal Employee Retirement Income Security Act (ERISA). Only about 40 percent of Connecticut residents are covered under fully insured group or individual health insurance plans or policies.

Many of these mandates have been in effect for many years, some for decades. The legislative history shows that some of the insurers/MCOs covered some of the mandated benefits in their plans even before the mandate was adopted. Thus it is difficult to currently assess the cost that these mandates may have added to premiums when they were enacted. The new cost that was added by the mandate is now embedded in total premium and is not easily identifiable at this point.

In some cases, the medical standard of care has changed since the adoption of the mandate and aligns much more closely now with the requirements of the mandate than it did at the time of the mandate's adoption, e.g. the diabetes treatment and self-management education mandates. In other cases, the dollar amount specified in the mandate has not been changed since the mandate was enacted and may be irrelevant now, e.g. the tumors and leukemia mandate. In the case of the mandate for coverage of off-label drugs for cancer treatment, two of the external references specified in the mandate no longer exist. Some of the benefits are also mandated by the federal government for employer-sponsored health plans. These federal mandates apply to all employer plans irrespective of the Connecticut mandate.

In light of these variables, it is difficult to assess whether the removal of a given mandate at this point would have any effect on premiums, or whether the service would continue to be covered by most plans, even in the absence of the state mandate. Indeed, many of the mandates are included in the majority of self-funded plans, which are not subject to state regulation.

The reviews provide an estimated cost to the State employee health plans for each mandate, including a calculation for those members of the retiree plans who do not participate in Medicare. These costs are based on the assumption that the State plans will continue to include all of the Connecticut mandated benefits, even though the State plans are now self-funded and are not required to comply with state mandates. It should be noted that the estimated cost to the State plans is calculated using the same weighted averages for all claims paid by Connecticut-domiciled insurers/MCOs as was used for the other cost calculations. The actual cost of the mandates to the State plans may be higher or lower, based on the actual benefit design of the State plans and the demographics of the covered lives (e.g., level of cost-sharing, average age of members, etc.).

Finally, these reviews do not attempt to assess the impact of the recently enacted federal Patient Protection and Affordable Care Act, since that was beyond the scope of P.A. 09-179. However, the reviews may provide useful information to Connecticut policymakers as they begin to plan for implementation of the federal health care reform.

Table 1 – Mandated Benefits Reviews by Volume				
Volume/ Chapter	Description	Individual policy statute	Group plan statute	Effective date
I.1	Diabetic Self Management Training	§ 38a-492e	§ 38a-518e	Jan. 2000
I.2	Prostate Cancer Screening	§ 38a-492g	§ 38a-518g	Jan. 2000
I.3	Ostomy-Related Supplies	§ 38a-492j	§ 38a-518j	Oct. 2000
I.4	Hearing Aids for Children Twelve and Under	§ 38a-490b	§ 38a-516b	Oct. 2001
I.5	Craniofacial Disorders	§ 38a-490c	§ 38a-516c	Oct. 2003
I.6	Inpatient, Outpatient, and One-day Dental Services	§ 38a-491a	§ 38a-517a	Jan. 2000
I.7	Diabetes Testing and Treatment	§ 38a-492d	§ 38a-518d	Oct. 1997
I.8	Birth to Three Program	§ 38a-490a	§ 38a-516a	July 1996
I.9	Lyme Disease Treatments	§ 38a-492h	§ 38a-518h	Jan. 2000
I.10	Colorectal Cancer Screening	§ 38a-492k	§ 38a-518k	Oct. 2001
I.11	Tumors and Leukemia	§ 38a-504	§ 38a-542	July 1994
II.1	Mammography and Breast Ultrasound	§ 38a-503	§ 38a-530	Oct. 2001
II.2	Maternity Minimum Stay	§ 38a-503c	§ 38a-530c	Oct. 1996
II.3	Mastectomy or Lymph Node Dissection (48 hours)	§ 38a-503d	§ 38a-530d	July 1997
II.4	Prescription Contraceptives	§ 38a-503e	§ 38a-530e	Oct. 1999
II.5	Infertility Diagnosis and Treatment	§ 38a-509	§ 38a-536	Oct. 2005
II.6	Autism Spectrum Disorder Therapies	§ 38a-488b	§ 38a-514b	Jan. 2009
II.7	Coverage for Newborn Infants	§ 38a-490	§ 38a-516	Oct. 1974
II.8	Blood Lead Screening and Risk Assessment	§ 38a-490d	(Indiv. only)	Oct. 1997
II.9	Preventive Pediatric Care and Blood Lead Screening	§ 38a-492c	§ 38a-518c	Oct. 1997
II.10	Low Protein Modified Food Products, Amino Acid Modified Preparations, and Specialized Formulas	§ 38a-492l	§ 38a-516d	Oct. 2006
II.11	Neurophysical Testing for Children Diagnosed with Cancer	NA	§ 38a-535	Oct. 1990
III.1	Psychotropic Drug Availability	§ 38a-476b	(Indiv. only)	Oct. 2001
III.2	Mental or Nervous Conditions	§ 38a-488a	§ 38a-514	Jan. 2000
III.3	Accidental Ingestion of Controlled Drug	§ 38a-492	§ 38a-518	July 1975
III.4	Denial of Coverage Prohibited for Health Care Services to Persons with an Elevated Blood Alcohol Content	§ 38a-498c	§ 38a-525c	Oct. 2006
III.5	Treatment of Medical Complications of Alcoholism	NA	§ 38a-533	Jan. 2000
III.6	Occupational Therapy	§ 38a-496	§ 38a-524	Oct. 1982
III.7	Services of Physician Assistants and Certain Nurses	§ 38a-499	§ 38a-526	Oct. 1984
III.8	Services Provided by the Veterans' Home	§ 38a-502	§ 38a-529	Oct. 1988
III.9	Direct Access to OB/GYNs	§ 38a-503b	§ 38a-530b	Oct. 1995
III.10	Chiropractic Services	§ 38a-507	§ 38a-534	Oct. 1989
IV.1	Experimental Treatments	§ 38a-483c	§ 38a-513b	Jan. 2000

Table 1 – Mandated Benefits Reviews by Volume				
Volume/ Chapter	Description	Individual policy statute	Group plan statute	Effective date
IV.2	Off-label Use of Cancer Drugs	§ 38a-492b	§ 38a-518b	Oct. 1994
IV.3	Cancer Clinical Trials	§ 38a-504a-g	§ 38a-542a-g	Jan. 2002
IV.4	Hypodermic Needles and Syringes	§ 38a-492a	§ 38a-518a	July 1992
IV.5	Prescription Drugs Removed from Formulary	§ 38a-492f	§ 38a-518f	Jan. 2000
IV.6	Home Health Care	§ 38a-493	§ 38a-520	Oct. 1975
IV.7	Ambulance Services	§ 38a-498	§ 38a-525	Oct. 2002
IV.8	Prescription Drug Coverage/Mail Order Pharmacies	§ 38a-510	§ 38a-544	July 1998 Group/July 2005 Indiv.
IV.9	Co-payments Regarding In-Network Imaging Services	§ 38a-511	§ 38a-550	May 2007
IV.10	Comprehensive Rehabilitation Services (mandatory offer)	(Group only)	§ 38a-523	1991
IV.11	Mobile Field Hospital	§ 38a-498b	§ 38a-525b	July 2005
IV.12	Pain Management	§ 38a-492i	§ 38a-518i	Jan. 2001
IV.13	Maternity Benefits and Pregnancy Care Following Policy Termination	(Group only)	§ 38a-547	

Table 2 – Mandated Benefits Reviews by Statute				
Group plan statute	Individual policy statute	Effective date	Description	Volume/ Chapter
§ 38a-513b	§ 38a-483c	Jan. 2000	Experimental Treatments	IV.1
§ 38a-514	§ 38a-488a	Jan. 2000	Mental or Nervous Conditions	III.2
§ 38a-514b	§ 38a-488b	Jan. 2009	Autism Spectrum Disorder Therapies	II.6
§ 38a-516	§ 38a-490	Oct. 1974	Coverage for Newborn Infants	II.7
§ 38a-516a	§ 38a-490a	July 1996	Birth to Three Program	I.8
§ 38a-516b	§ 38a-490b	Oct. 2001	Hearing Aids for Children Twelve and Under	I.4
§ 38a-516c	§ 38a-490c	Oct. 2003	Craniofacial Disorders	I.5
§ 38a-516d	§ 38a-492l	Oct. 2006	Neurophysical Testing for Children Diagnosed with Cancer	II.11
§ 38a-517a	§ 38a-491a	Jan. 2000	Inpatient, Outpatient, and One-day Dental Services	I.6
§ 38a-518	§ 38a-492	July 1975	Accidental Ingestion of Controlled Drug	III.3
§ 38a-518a	§ 38a-492a	July 1992	Hypodermic Needles and Syringes	IV.4
§ 38a-518b	§ 38a-492b	Oct. 1994	Off-label Use of Cancer Drugs	IV.2
§ 38a-518c	§ 38a-492c	Oct. 1997	Low Protein Modified Food Products, Amino Acid Modified Preparations, and Specialized Formulas	II.10
§ 38a-518d	§ 38a-492d	Oct. 1997	Diabetes Testing and Treatment	I.7
§ 38a-518e	§ 38a-492e	Jan. 2000	Diabetic Self Management Training	I.1

Table 2 – Mandated Benefits Reviews by Statute				
Group plan statute	Individual policy statute	Effective date	Description	Volume/ Chapter
§ 38a-518f	§ 38a-492f	Jan. 2000	Prescription Drugs Removed from Formulary	IV.5
§ 38a-518g	§ 38a-492g	Jan. 2000	Prostate Cancer Screening	I.2
§ 38a-518h	§ 38a-492h	Jan. 2000	Lyme Disease Treatments	I.9
§ 38a-518i	§ 38a-492i	Jan. 2001	Pain Management	IV.12
§ 38a-518j	§ 38a-492	Oct. 2000	Ostomy-Related Supplies	I.3
§ 38a-518k	§ 38a-492k	Oct. 2001	Colorectal Cancer Screening	I.10
§ 38a-520	§ 38a-493	Oct. 1975	Home Health Care	IV.6
§ 38a-523	(Group only)	1991	Comprehensive Rehabilitation Services (mandatory offer)	IV.10
§ 38a-524	§ 38a-496	Oct. 1982	Occupational Therapy	III.6
§ 38a-525	§ 38a-498	Oct. 2002	Ambulance Services	IV.7
§ 38a-525b	§ 38a-498b	July 2005	Mobile Field Hospital	IV.11
§ 38a-525c	§ 38a-498c	Oct. 2006	Denial of Coverage Prohibited for Health Care Services to Persons with an Elevated Blood Alcohol Content	III.4
§ 38a-526	§ 38a-499	Oct. 1984	Services of Physician Assistants and Certain Nurses	III.7
§ 38a-529	§ 38a-502	Oct. 1988	Services Provided by the Veterans' Home	III.8
§ 38a-530	§ 38a-503	Oct. 2001	Mammography and Breast Ultrasound	II.1
§ 38a-530b	§ 38a-503b	Oct. 1995	Direct Access to OB/GYNs	III.9
§ 38a-530c	§ 38a-503c	Oct. 1996	Maternity Minimum Stay	II.2
§ 38a-530d	§ 38a-503d	July 1997	Mastectomy or Lymph Node Dissection (48 hours)	II.3
§ 38a-530e	§ 38a-503e	Oct. 1999	Prescription Contraceptives	II.4
§ 38a-533	(Group only)	Jan. 2000	Treatment of Medical Complications of Alcoholism	III.5
§ 38a-534	§ 38a-507	Oct. 1989	Chiropractic Services	III.10
§ 38a-535	(Group only)	Oct. 1990	Preventive Pediatric Care and Blood Lead Screening	II.9
§ 38a-536	§ 38a-529	Oct. 2005	Infertility Diagnosis and Treatment	II.5
§ 38a-542	§ 38a-504	July 1994	Tumors and Leukemia	I.11
§ 38a-542a-g	§ 38a-504a-g	Jan. 2002	Cancer Clinical Trials	IV.3
§ 38a-544	§ 38a-510	July 1998 Group/ July 2005 Indiv.	Prescription Drug Coverage/Mail Order Pharmacies	IV.8
§ 38a-547	(Group only)		Maternity Benefits and Pregnancy Care Following Policy Termination	IV.13
§ 38a-550	§ 38a-511	May 2007	Co-payments Regarding In-Network Imaging Services	IV.9
(Indiv. only)	§ 38a-490d	Oct. 1997	Blood Lead Screening and Risk Assessment	II.8
(Indiv. only)	§ 38a-476b	Oct. 2001	Psychotropic Drug Availability	III.1

Table 3 – Mandated Benefits, Impact on Premium		
Volume/ Chapter	Description	Impact on Group Premium
I.1	Diabetic Self Management Training	0%
I.2	Prostate Cancer Screening	0.1%
I.3	Ostomy-Related Supplies	0%
I.4	Hearing Aids for Children Twelve and Under	0%
I.5	Craniofacial Disorders	0%
I.6	Inpatient, Outpatient, and One-day Dental Services	0%
I.7	Diabetes Testing and Treatment	1.5%
I.8	Birth to Three Program	0.1%
I.9	Lyme Disease Treatments	0.1%
I.10	Colorectal Cancer Screening	1.1%
I.11	Tumors and Leukemia	3.7%
II.1	Mammography and Breast Ultrasound	0.8%
II.2	Maternity Minimum Stay	0.6%
II.3	Mastectomy or Lymph Node Dissection (48 hours)	0%
II.4	Prescription Contraceptives	0.4%
II.5	Infertility Diagnosis and Treatment	0.9%
II.6	Autism Spectrum Disorder Therapies	0%
II.7	Coverage for Newborn Infants	1.7%
II.8	Blood Lead Screening and Risk Assessment	0%
II.9	Preventive Pediatric Care and Blood Lead Screening	0.1%
II.10	Low Protein Modified Food Products, Amino Acid Modified Preparations, and Specialized Formulas	0%
II.11	Neurophysical Testing for Children Diagnosed with Cancer	0.6%
III.1	Psychotropic Drug Availability	2.5%
III.2	Mental or Nervous Conditions	2.8%
III.3	Accidental Ingestion of Controlled Drug	0%
III.4	Denial of Coverage Prohibited for Health Care Services to Persons with an Elevated Blood Alcohol Content	0%
III.5	Treatment of Medical Complications of Alcoholism	0.1%
III.6	Occupational Therapy	0.3%
III.7	Services of Physician Assistants and Certain Nurses	0%
III.8	Services Provided by the Veterans' Home	0.1%

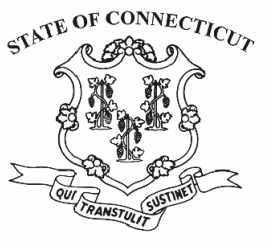
Table 3 – Mandated Benefits, Impact on Premium		
Volume/ Chapter	Description	Impact on Group Premium
III.9	Direct Access to OB/GYNs	0%
III.10	Chiropractic Services	0.8%
IV.1	Experimental Treatments	0%
IV.2	Off-label Use of Cancer Drugs	1.0%
IV.3	Cancer Clinical Trials	0%
IV.4	Hypodermic Needles and Syringes	0%
IV.5	Prescription Drugs Removed from Formulary	0%
IV.6	Home Health Care	0.5%
IV.7	Ambulance Services	0.8%
IV.8	Prescription Drug Coverage/Mail Order Pharmacies	0%
IV.9	Co-payments Regarding In-Network Imaging Services	0.3%
IV.10	Comprehensive Rehabilitation Services (mandatory offer)	0.8%
IV.11	Mobile Field Hospital	0%
IV.12	Pain Management	0%
IV.13	Maternity Benefits and Pregnancy Care Following Policy Termination	0%
	Total Impact on Premium	21.9%

Appendix I

House Bill No. 5018

Public Act No. 09-179

An act concerning reviews of health insurance benefits mandated in the State of Connecticut



House Bill No. 5018

Public Act No. 09-179

AN ACT CONCERNING REVIEWS OF HEALTH INSURANCE BENEFITS MANDATED IN THIS STATE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2009*) (a) As used in this section:

(1) "Commissioner" means the Insurance Commissioner.

(2) "Mandated health benefit" means an existing statutory obligation of, or proposed legislation that would require, an insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that offers individual or group health insurance or medical or health care benefits plan in this state to: (A) Permit an insured or enrollee to obtain health care treatment or services from a particular type of health care provider; (B) offer or provide coverage for the screening, diagnosis or treatment of a particular disease or condition; or (C) offer or provide coverage for a particular type of health care treatment or service, or for medical equipment, medical supplies or drugs used in connection with a health care treatment or service. "Mandated health benefit" includes any proposed legislation to expand or repeal an existing statutory obligation relating to health insurance coverage or medical benefits.

(b) (1) There is established within the Insurance Department a

health benefit review program for the review and evaluation of any mandated health benefit that is requested by the joint standing committee of the General Assembly having cognizance of matters relating to insurance. Such program shall be funded by the Insurance Fund established under section 38a-52a of the general statutes. The commissioner shall be authorized to make assessments in a manner consistent with the provisions of chapter 698 of the general statutes for the costs of carrying out the requirements of this section. Such assessments shall be in addition to any other taxes, fees and moneys otherwise payable to the state. The commissioner shall deposit all payments made under this section with the State Treasurer. The moneys deposited shall be credited to the Insurance Fund and shall be accounted for as expenses recovered from insurance companies. Such moneys shall be expended by the commissioner to carry out the provisions of this section and section 2 of this act.

(2) The commissioner shall contract with The University of Connecticut Center for Public Health and Health Policy to conduct any mandated health benefit review requested pursuant to subsection (c) of this section. The director of said center may engage the services of an actuary, quality improvement clearinghouse, health policy research organization or any other independent expert, and may engage or consult with any dean, faculty or other personnel said director deems appropriate within The University of Connecticut schools and colleges, including, but not limited to, The University of Connecticut (A) School of Business, (B) School of Dental Medicine, (C) School of Law, (D) School of Medicine, and (E) School of Pharmacy.

(c) Not later than August first of each year, the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall submit to the commissioner a list of any mandated health benefits for which said committee is requesting a review. Not later than January first of the succeeding year, the

commissioner shall submit a report, in accordance with section 11-4a of the general statutes, of the findings of such review and the information set forth in subsection (d) of this section.

(d) The review report shall include at least the following, to the extent information is available:

(1) The social impact of mandating the benefit, including:

(A) The extent to which the treatment, service or equipment, supplies or drugs, as applicable, is utilized by a significant portion of the population;

(B) The extent to which the treatment, service or equipment, supplies or drugs, as applicable, is currently available to the population, including, but not limited to, coverage under Medicare, or through public programs administered by charities, public schools, the Department of Public Health, municipal health departments or health districts or the Department of Social Services;

(C) The extent to which insurance coverage is already available for the treatment, service or equipment, supplies or drugs, as applicable;

(D) If the coverage is not generally available, the extent to which such lack of coverage results in persons being unable to obtain necessary health care treatment;

(E) If the coverage is not generally available, the extent to which such lack of coverage results in unreasonable financial hardships on those persons needing treatment;

(F) The level of public demand and the level of demand from providers for the treatment, service or equipment, supplies or drugs, as applicable;

(G) The level of public demand and the level of demand from

providers for insurance coverage for the treatment, service or equipment, supplies or drugs, as applicable;

(H) The likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states;

(I) The relevant findings of state agencies or other appropriate public organizations relating to the social impact of the mandated health benefit;

(J) The alternatives to meeting the identified need, including, but not limited to, other treatments, methods or procedures;

(K) Whether the benefit is a medical or a broader social need and whether it is consistent with the role of health insurance and the concept of managed care;

(L) The potential social implications of the coverage with respect to the direct or specific creation of a comparable mandated benefit for similar diseases, illnesses or conditions;

(M) The impact of the benefit on the availability of other benefits currently offered;

(N) The impact of the benefit as it relates to employers shifting to self-insured plans and the extent to which the benefit is currently being offered by employers with self-insured plans;

(O) The impact of making the benefit applicable to the state employee health insurance or health benefits plan; and

(P) The extent to which credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community determines the treatment, service or equipment, supplies or drugs, as applicable, to be safe and effective; and

(2) The financial impact of mandating the benefit, including:

(A) The extent to which the mandated health benefit may increase or decrease the cost of the treatment, service or equipment, supplies or drugs, as applicable, over the next five years;

(B) The extent to which the mandated health benefit may increase the appropriate or inappropriate use of the treatment, service or equipment, supplies or drugs, as applicable, over the next five years;

(C) The extent to which the mandated health benefit may serve as an alternative for more expensive or less expensive treatment, service or equipment, supplies or drugs, as applicable;

(D) The methods that will be implemented to manage the utilization and costs of the mandated health benefit;

(E) The extent to which insurance coverage for the treatment, service or equipment, supplies or drugs, as applicable, may be reasonably expected to increase or decrease the insurance premiums and administrative expenses for policyholders;

(F) The extent to which the treatment, service or equipment, supplies or drugs, as applicable, is more or less expensive than an existing treatment, service or equipment, supplies or drugs, as applicable, that is determined to be equally safe and effective by credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;

(G) The impact of insurance coverage for the treatment, service or equipment, supplies or drugs, as applicable, on the total cost of health care, including potential benefits or savings to insurers and employers resulting from prevention or early detection of disease or illness related to such coverage;

(H) The impact of the mandated health care benefit on the cost of health care for small employers, as defined in section 38a-564 of the general statutes, and for employers other than small employers; and

(I) The impact of the mandated health benefit on cost-shifting between private and public payors of health care coverage and on the overall cost of the health care delivery system in the state.

Sec. 2. (*Effective July 1, 2009*) The commissioner shall carry out a review as set forth in section 1 of this act of statutorily mandated health benefits existing on or effective on July 1, 2009. The commissioner shall submit, in accordance with section 11-4a of the general statutes, the findings to the joint standing committee of the General Assembly having cognizance of matters relating to insurance not later than January 1, 2010.

Approved June 30, 2009

Appendix II

Ingenix Consulting

Summary Report

Covered By Public Act
Number 09-179
for
The State of Connecticut

INGENIX CONSULTING—

SUMMARY REPORT For The STATE OF CT On The 45 HEALTH INSURANCE MANDATES Covered By PUBLIC ACT NUMBER 09-179

January 5, 2011

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TABLE OF CONTENTS:

I. INTRODUCTION:

This summary report serves to record the findings of Ingenix Consulting (IC) pursuant to the engagement to provide actuarial services to the State of CT in conjunction with Substitute House Bill No. 5021, Public Acts 09-179. This summary follows four prior reports on the mandates covered by Sets One through Four respectively. It is intended only to provide overarching comments on the project. The four reports cover each set of mandates far more thoroughly. In order to follow this summary, it is first necessary to read the four reports.

IC was retained by the state to assess 45 existing health insurance mandates. The mandates were reviewed with respect to cost, socio-economic impact, and effect on the system for the finance and delivery of health care. Most of the mandates were for particular benefits; others require the coverage of certain types of providers. No eligibility mandates were reviewed. Rating regulations, which do not meet the definition of mandate used for this project, were not included in this study.

IC partnered with a workgroup that included individuals from the UConn Center for Public Health and Health Policy as well the CT Insurance Department. The work of IC is contained in these four reports and this overarching summary.

A thorough and systematic evaluation of the value and utility of the mandates was not within the scope of this project. The four reports and this summary are intended to present quantitative and qualitative facts and actuarial judgments about the 45 mandates. Different stakeholders will perceive these points from diverse perspectives.

For this project, the six health insurers domiciled in CT were asked to submit their claim data showing how much these mandates cost in 2007 and 2008. For some of the mandates, IC also supplemented the health carrier data with data from their CT and national databases. Costs were determined with respect to the insurers and people insured. Medical costs were analyzed for each mandate, as were non-medical costs. Interviews were conducted with many medical providers who shared their expertise on the conditions, illness, and diseases covered by the mandates.

Costs were analyzed for the mandates in existence in 2009. These were projected to 2010 for fully insured group plans in CT. A subsequent cost study was conducted to establish cost projections from 2011 through 2014. These are shown in the appendices to this summary.

This summary also addresses mandate coverage by self-funded plans in CT since this was not addressed in the four prior reports. Self-funded plans are outside of the regulatory scope of state mandates; however, most self-funded employer plans cover most of the mandates.

Many of the mandates have been in existence for a decade or decades. The oldest mandates came about at a time when health insurance contracts were more limited with respect to the scope of covered benefits. At that time, there were different types of health insurance such as combinations of a basic hospital plan and an overlaying supplemental major medical policy. These plans may have excluded mental health and substance abuse services, as well as the services of physical, speech, and occupational therapists. Neither did these plans cover “orphan” diseases. These are usually inherited medical conditions that affect a very small percentage of the population. Many have been discovered in the past few decades, such as the detrimental effect that cancer treatment may have on a child’s brain development. Although these diseases affect only a small vulnerable subpopulation, the mandate may

relieve a significant cost burden on those families coping with these diseases. Over time, health insurance plans have evolved to cover a broader range of medical goods and services. While some critics blame mandates for the rise in health insurance premiums, others perceive a number of other factors, such as the march of medical technology and advancements in the general practice of medicine. Some cite the progress in medicine and health care as one of the reasons behind the existence of many mandates. Regardless, consumers of health insurance are protected by mandates. It is necessary to examine each mandate on its own in order to understand its origin, benefit, and cost. In some cases, by imposing a benefit or provider mandate, the state creates a level playing field for all the various HMOs and health insurers. In this sense, sometimes subtle inequities in coverage can be addressed when all carriers must cover the same minimum established by the mandate.

Several mandates had internal dollar limits. These are: hearing aids for children, ostomy supplies, birth to three, accidental ingestion of controlled drugs, and aspects of the cancer mandate. Over time, these dollar limits may become outdated due to the effects of inflation. The evolution of medical technology may also contribute to dollar limits becoming outdated.

The process of establishing these various costs for the 45 mandates involved some actuarial calculation and judgment. The carrier data was not 100% reliable, and some carriers had difficulty securing data for some mandates. All the carriers had difficulty obtaining data for a few. Ingenix Consulting data was used to supplement the carrier data. In some cases, costs were established using incidence and prevalence rates obtained from the medical literature.

The list of mandates varies considerably from state to state. In examining CT's mandates relative to other states, it is apparent that CT is not first or last in number of mandates covered, but toward the higher end of the list. What is striking is the variance of mandates covered from state to state and the lack of consistency. This may reflect the local political process through which mandates arise, and the state-based nature of insurance regulation.

II. EXECUTIVE SUMMARY

In the course of this study, IC examined not only the costs, but also many of the socio-economic implications of the 45 mandates. It is clear that many of them add to the cost of health insurance. Most are also an important part of health coverage at this time. Some mandates protect a small but vulnerable special population with a medical condition that affects few people. At the other end of the spectrum, other mandates, such as those pertaining to preventive care, affect all insured people and serve to promote the overall health of the entire insured population.

The reports focused primarily on fully insured Group plans. It also comments on Individual plans. The Group plans are further segmented into small group and large group; the majority of those insured by group plans are in large group, defined as more than 50 employees.

The 45 mandates in this report comprise roughly 22% of the 2010 medical cost of health insurance in CT for the average person covered by a group plan. This is the medical cost paid by insurers and does not include the cost paid by the member in the form of deductibles, copays, and coinsurance. This percentage, 22%, likely overstates the true medical cost of the mandates for several reasons. Some of the benefits required by the mandates were already covered prior to the passage of the mandate. The cost of other mandates may also be

overstated for other reasons. The psychotropic drugs mandate, for example, requires health insurers to cover only the most effective psychotropic drug, but insurers reported the total cost of all psychotropic drugs. In other cases, the insurance carriers may have erred on the safe side and captured more claims for a particular mandate than the mandate requires. There is also some minor overlap in the covered services of several mandates.

There are three general categories of cost that were examined in the course of this project:

- Medical cost paid by insurers,
- Non-medical expenses paid by insurers, and
- Member Cost-Sharing, the responsibility of the insured person.

The 22% reported above is medical cost paid by insurers. In conjunction with this medical cost, there is an associated non-medical expense paid by the insurer. This is sometimes referred to as "retention" in the four reports. It includes administrative (operational) expense as well as a risk/profit charge. Embedded in the administrative cost is the expense for premium tax; this charge is 1.75% of premium, and carriers must pay it to the state for all fully-insured plans. Non-benefit expense for Group plans is about 16.7% of premium; this is about 20% of the medical cost, where medical cost is 83.3% of premium. These 45 mandates are responsible for 22% of the total medical cost of Group health plans. Similarly, with non-medical expense included, the cost of the 45 mandates is 22% of the total health insurance premium for group plans, since the retention applying to the mandates is the same percentage applying to all medical expenses.

The third category of cost is member cost-sharing. These amounts are paid when people use their insurance and seek medical care. They consist of deductibles, coinsurance, and copays and are paid at or after the time of service. For group plans, the member cost-sharing associated with the 45 mandates is about 17% of the medical cost of the mandates. This is somewhat higher than the overall member cost-sharing for all medical care, which is about 15% of total medical cost.

In addition to cost-sharing, those with group health coverage often have financial responsibility for a portion of the annual premium ranging from about 10% to 50%. On average, this is roughly in the vicinity of 25% in CT. Employers usually obtain these funds through payroll withholding. The portion of the premium paid by those in group plans is not considered part of the member cost-sharing. It is considered to be part of the member cost-burden of care. Member cost-sharing is examined in the financial/economic section of each of the four reports and is discussed at greater length there. Those covered by Individual plans pay for the full cost of their insurance premiums.

Individual plans were also examined during this project, but the data for them was based on far fewer lives than that for Group plans. Thus there is less confidence in the Individual results. For Individual plans, only 42 of the 45 mandates apply. These 42 mandates constitute 18% of the overall medical cost, as well as 18% of the health insurance premium for Individual plans. As for Group plans, this percentage is likely overstated for similar reasons.

As a percentage of medical cost, the member cost-sharing for Individual plans is considerably greater than Group for total cost and for the cost of the 42 mandates. For Individual plans, member cost-sharing is about 27% of the medical cost for the 42 mandates. This is somewhat lower than the cost-sharing for all benefits. According to the carrier data submitted, member cost-sharing in Individual plans is about 33% of total cost for all benefits.

For Group plans, the medical cost for the five most costly mandates is 12% of the total medical cost. That is, slightly more than half of the cost of all forty-five mandates is found in these top five. The lowest cost eighteen mandates comprise less than 0.1% of the total medical cost, which is less than one one-hundredth of the cost of the top five for Group plans. Further information about the cost of the mandates is contained in a subsequent section of this summary titled "IV. Cost of Mandates."

Many of the lowest cost mandates require a medical service or services that are utilized by extremely few individuals. An example of this is neurological testing for children undergoing chemotherapy; another is orthodontic treatment for children born with cranio-facial disorders. Even mandates that cover services utilized by a significant portion of the population might not be all that costly if the service itself is of low unit cost. For example, a test costing $30 that is performed once annually on 10% of the insured population will cost the average member $3 per year, which translates into a $0.25 medical cost per member per month, which is less than 0.1% of overall medical cost. The lowest cost mandates involve a low cost service that is utilized by very few people.

In addition to cost, various socio-economic aspects of the mandates were examined. This analysis was not as easily generalized to all 45 mandates as the cost analysis. The cost of some of the mandates, such as psychotropic drugs and copayment limits on complex imaging, have been increasing at a faster rate than the rest of medical services over the past decade due to advancements in medicine.

III. OVERVIEW

"Fully insured" plans are distinguished from "self-funded plans" in this report. The latter are not within the purview of the mandate regulations. Self-funded plans are provided by employers, usually larger employers, to employees and their dependents. They are governed by the Employee Retirement Income Security Act (ERISA) of 1974, not by state insurance law. As such, they are not required to cover the mandates unless it is a federal mandate also. About half of the group coverage in CT and the US is self-funded. There is no self-funded coverage for individuals; when individuals are without any health insurance coverage, they are said to be uninsured. Most self-funded groups have medical stop loss reinsurance coverage to protect themselves against 1) the risk of any covered individual's annual claims exceeding a catastrophic threshold, or 2) the group's total claims exceeding some aggregate threshold. Individuals in high deductible plans have a somewhat similar arrangement whereby they can be thought of as "self-funding" their medical costs up to the deductible, often with the use of an underlying health savings account or health reimbursement account.

A. FULLY INSURED COVERAGE

There are well over a million people with fully insured coverage in CT. Fully insured coverage can be obtained through group or individual health insurance plans. Almost 90% of the fully insured coverage in CT is through group policies. Individual policies tend to be purchased by those working for themselves or small groups that do not offer health coverage. They may be people between jobs, or who otherwise have no access to coverage under a group plan. Access to insurance is tantamount to access to health care. Since those with individual coverage must pay their own premium in addition to any cost-sharing required by the plan, the cost burden is greater for them than for those with group coverage. For the latter, the majority of the premium cost is generally paid by the employer. The data also showed that those

people with individual coverage incur a larger percentage of the total cost of their care in the form of deductibles, copays, and coinsurance. In the four reports, we refer to this as member cost-sharing.

Unlike group coverage, new applications for Individual plans are reviewed and must pass initial underwriting of each person in order to be approved. Individual plans may impose a pre-existing exclusion on new members that will apply temporarily. With respect to limitations for pre-existing conditions, IC considered how they would affect the mandates for Individual plans. It was concluded that they might have a short term impact on some mandates, which would be difficult to measure. However, the long term cost would not be significantly changed.

Each of the mandates is discussed in the prior four reports covering Sets One through Four. Costs are examined, and socio-economic and financial implications are discussed. In order to understand each mandate, some medical background must be understood; this is also provided in the four actuarial reports.

B. SELF-FUNDED COVERAGE

All self-funded coverage is group coverage; that is, it is employer-based. Some self-funded plans may consist of multiple employers. Self-funded employers tend to be larger ones. Although there are exceptions, the largest employers tend to have more comprehensive benefit plans with less member cost-sharing than smaller employer plans. Public employers, such as towns, cities, and municipalities tend to have the most generous ("rich") health plans. These plans tend to cover services that other plans might not. For example, they may have an unlimited benefit for chiropractic care. They may also cover hearing aids and vision care, or other such non-standard medical benefits and services. These benefits are beyond the scope of traditional Medicare Part A and Part B coverage. These public employer plans are also "richer" insofar as they often have lower member cost-sharing in the form of deductibles, copays, and coinsurance. Large self-funded employers also tend to embrace wellness and disease management programs before others because they have high stakes in the productivity of their workforce and the resources to strive to improve it.

A survey was sent to the six carriers. It contained questions about the number of groups and insured members covered by each of forty of the mandates. The results were incomplete, but the data indicated that most self-funded members are covered by most of the mandates.

- 26 mandates, about 2/3, are included by 75% of the self-funded plans.
- 13 mandates, about 1/3, are included by 90% of the groups and cover 90% of the members.

9 of the 12 more expensive mandates (with cost of $1 PMPM or more) are covered by 75% of the self-funded groups and cover 77% of members. Only 5 of these 12 mandates are covered by 90% of groups and members.

Some survey responses were questionable in light of federal mandates that require coverage of certain mandates by self-funded groups and HIPAA privacy requirements that apply. These include Mental Health Parity, Minimum Hospital Stay following Childbirth, and Denial of Coverage to People with Elevated Blood Alcohol Content.

Some state mandates are also part of the federal Patient Protection and Affordable Care Act (PPACA). Self-funded groups will be required to cover newborn infants, as is now required of insured groups by the state mandate. Other state-required benefits are now mandated by PPACA for plans that fail to maintain "grandfathered" status after September 23, 2010. These

federal mandates include 100% coverage preventative care and direct access to obstetricians and gynecologists without a referral. It is our understanding the federal preventative care mandate would encompass the current state mandates of pediatric preventative care, screening for blood lead, colorectal cancer, prostate cancer, and breast cancer (including mammograms). Also, some aspects of the state mandated "birth to three" program would fall under the federal preventative care mandate.

As employers make other changes to their benefits and their share of the cost, more and more self-funded plans that were originally "grandfathered" will lose this status over time. When that occurs, these plans will have to add the 100% preventative care benefit (no member cost-sharing) and direct access to obstetricians and gynecologists.

The carrier survey did not seek reasons why self-funded groups cover one state mandate but not another. The benefit prevalence data suggest that cost is not the driving factor as to whether a self-funded group decides to include a state-mandated benefit. Indeed, our survey indicates a higher prevalence of mandates costing over $1 PMPM than of all the mandates in total. The only two mandates with higher than $1 PMPM cost that are not covered by at least 75% of the self-funded groups are psychotropic drugs, infertility treatment, and contraceptive drugs, where religious considerations may be a factor in the decision not to cover the latter.

IV. COST OF MANDATES

Over the past fifty years, medical technology has made astonishing progress. Life expectancy has increased substantially, and many diseases that were a death sentence twenty-five or fifty years ago can now be treated and, if not cured, at least held at bay while life is extended. This technological progress shows up in the diagnosis and treatment of sickness and disease. It is also seen in medical devices and pharmaceuticals. Over the past several decades, medical cost has increased annually at a rate roughly double that of inflation. Medical technology and advancements in medicine in general have contributed to that increase, as have other factors.

As explained previously in the Executive Summary, the 45 mandates in this report comprise roughly 22% of the 2010 medical cost of health insurance in CT for the average person covered by a group plan. This is the cost paid by insurers and does not include the cost paid by the member in the form of deductibles, copays, and coinsurance. As stated in the Executive Summary, this percentage, 22%, likely overstates the true cost of the mandates for several reasons. Some of the benefits required by the mandates were already covered prior to the passage of the mandate. The cost of other mandates may also be overstated for other reasons. The psychotropic drugs mandate, for example, requires health insurers to cover only the most effective psychotropic drug, but insurers reported the total cost of all psychotropic drugs. In other cases, the insurance carriers may have erred on the safe side and captured more claims for a particular mandate than the mandate requires. There is also some minor overlap in the covered services of several mandates.

The medical cost of the top five mandates comprises 12% of the total medical cost for Group:

- Cancer, Tumors, Leukemia, etc.
- Mental Health and Substance Abuse Coverage
- Psychotropic Drugs--Most Effective Drug
- Diabetes Diagnosis and Treatment, Equipment and Supplies
- Newborn Coverage

Some of the cost for these top five was already covered prior to the passage of the mandates.

The medical cost of the next five mandates comprises an additional 5% of the total medical cost for Group plans:

- Colorectal Cancer Screening
- Off-Label Use of Cancer Drugs
- Infertility
- Mammography
- Chiropractors

The remaining 35 mandates cost 5% for Group plans. Of these 35, 29 have a medical cost of $1 per member per month (PMPM) or less; and 18 of these 29 cost $0.05 PMPM or less. The lowest cost 18 mandates represent less than 0.1% of the overall cost of medical care.

The highest cost mandate is a broad-based and multifaceted one that covers cancer and has a 2010 medical paid cost of $11 PMPM. It is not a benefit that could be easily removed from a health insurance policy today, although perhaps some minor aspects of it could be. For example, the cancer mandate requires insurers to pay up to $300 for a wig following chemotherapy; this component of the cancer mandate is of *de minimis* cost. Similarly, other higher cost mandates, such as diabetes and mammography, are considered part of the basic package of essential benefits covered by health insurance and thus not easily removed.

The member cost-sharing associated with the 45 mandates for Group plans is about 17% of their medical cost, which is about 3.7% of total medical cost (3.7% = 17% x 22%). This cost-sharing occurs in the form of deductibles, copays, and coinsurance. The member cost sharing for Individual plans is significantly greater as a percentage of total medical cost.

For Group plans, the non-medical expenses associated with the mandates is about 16.7% of premium; this is about 20% of their medical cost. These non-medical expenses consist of administrative costs and profit/risk charges. Embedded in the administrative cost for fully insured plans is a premium tax charge of 1.75% of premium.

There was less than one-twelfth as much carrier data for Individual plans as there was for Group. For this reason, we are less confident in the statistics calculated for Individual. In aggregate, for Individual plans, the mandates cost about 18% of medical cost. As for Group plans, this 18% may be overstated. For Individual plans, the member cost-sharing on the mandates is about 27% of the medical cost, which is equal to 4.9% of overall medical cost (4.9% = 27% x 18%). This is greater than for Group. As a percentage of Allowed cost for all health care services, Individual plans typically require about twice as much member cost-sharing as Group. This is explained in each of the four reports. Individual plans typically charge a greater percentage of premium for administrative cost and profit than Group plans; this means that non-medical expense, as a percentage of medical cost, is generally greater for Individual than Group.

For Individual plans, the non-medical expenses associated with the mandates is about 30% of their medical cost. These are administrative costs and profit, also called retention in the four reports. As a percent of medical cost, both member cost-sharing and retention are greater for Individual plans than Group.

The first two of the following appendices contain per member per month (PMPM) cost data for Group plans. The first shows various 2010 costs of each of the 45 mandates as explained in

the four reports. The second is a five year summary that shows paid medical cost only for each of the 45 mandates projected from 2010 through 2014. The third appendix shows 2010 PMPM costs for Individual plans; these cost estimates are less reliable than those of Group. The fourth appendix shows the total cost for Group and Individual combined, with and without cost-sharing and retention; underlying assumptions are noted on the appendix. The fifth appendix shows the results of the self-funded survey. Although all six carriers responded to it, one gave numerical answers for only five of the mandates.

LIMITATIONS IN USE:

This study was conducted by IC exclusively for the State of CT, specifically and solely as it applies to the evaluation of the forty-five mandates covered by Public Act Number 09-179. This report is not intended for any other application or purpose.

I, Daniel Bailey, am Director of Actuarial Services with Ingenix Consulting. I am a fellow of the Society of Actuaries and a member of the American Academy of Actuaries, in good standing, and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. Please contact me if you have questions. My e-mail address is Daniel.Bailey@IngenixConsulting.com, and my office phone is 860-221-0245.

Daniel Bailey, FSA, MAAA

APPENDIX ONE
GROUP COVERAGE

	Mandate	Citation	PROJECTED 2010 PMPM AMOUNTS A ALLOWED	B COST SHARE	C = A - B PAID	D RETEN-TION	E =C + D PAID + RETENTION	F PREM-IUM
1	Orthodontic Treatment for Craniofacial Disorders	38a-490c; 38a-516c	$0.02	$0.00	**$0.02**	$0.00	**$0.02**	0.0%
2	Inpatient Dental	38a-491a; 38a-517a	$0.06	$0.01	**$0.05**	$0.01	**$0.06**	0.0%
3	Diabetes Testing and Treatment	38a-492d; 38a-518d	$5.45	$0.85	**$4.60**	$0.92	**$5.52**	1.5%
4	Diabetes Outpatient Self-Management Training	38a-492e; 38a-518e	$0.07	$0.01	**$0.06**	$0.01	**$0.07**	0.0%
5	Screening for Prostate Cancer	38a-492g; 38a-518g	$0.22	$0.03	**$0.19**	$0.04	**$0.23**	0.1%
6	Lyme Disease Treatment	38a-492h; 38a-518h	$0.35	$0.07	**$0.28**	$0.06	**$0.34**	0.1%
7	Ostomy Appliances and Supplies	38a-492j; 38a-518j	$0.07	$0.01	**$0.06**	$0.01	**$0.07**	0.0%
8	Colorectal Cancer Screening	38a-492k; 38a-518k	$3.90	$0.50	**$3.40**	$0.68	**$4.08**	1.1%
9	Tumors and Leukemia, etc	38a-504; 38a-542	$12.17	$1.17	**$11.00**	$2.20	**$13.20**	3.7%
10	Birth-to-Three Program	38a-490a; 38a-516a	$0.23	$0.01	**$0.22**	$0.04	**$0.26**	0.1%
11	Hearing Aids for Children 12 and under	38a-490b; 38a-516b	$0.01	$0.00	**$0.01**	$0.00	**$0.01**	0.0%
12	Mammography and breast ultrasound	38a-503; 38a-530	$2.67	$0.13	**$2.54**	$0.51	**$3.05**	0.8%
13	Maternity care and postpartum care (48/96 hours) (net new cost)	38a-503c; 38a-530c	$1.97	0.12	**$1.85**	$0.37	**$2.22**	0.6%
14	Mastectomy or lymph node dissection (48 hours) (net new cost)	38a-503d; 38a-530d	$0.11	0.01	**$0.10**	$0.02	**$0.12**	0.0%
15	Prescription contraceptives	38a-503e; 38a-530e	$2.21	$1.01	**$1.20**	$0.24	**$1.44**	0.4%
16	Infertility diagnosis and treatment	38a-509; 38a-536	$3.03	$0.23	**$2.80**	$0.56	**$3.36**	0.9%
17	Autism Spectrum Disorder Therapies	38a-488b; 38a-514b	$0.04	$0.01	**$0.03**	$0.01	**$0.04**	0.0%
18	Coverage for Newborn Infants	38a-490; 38a-516	$5.09	$0.13	**$4.96**	$0.99	**$5.95**	1.7%
19	Blood Lead Screening and Risk Assessment	38a-490d	$0.01	$0.00	**$0.01**	$0.00	**$0.01**	0.0%
20	Preventive Pediatric Care --Group Only, Excludes Blood Lead Test	38a-535	$1.98	$0.07	**$1.91**	$0.38	**$2.29**	0.6%
21	Low Protein Modified Food Products, Amino Acid Modified Preparations, etc.	38a-492c; 38a-518c	$0.25	$0.01	**$0.24**	$0.05	**$0.29**	0.1%
22	Neuropsychological Testing for Children Diagnosed with Cancer	38a-492l; 38a-516d	$0.00	$0.00	**$0.00**	$0.00	**$0.00**	0.0%
23	Standards re Psychotropic Drug Availability in Health Plans	38a-476b; 38a-476b	$9.65	$2.15	**$7.50**	$1.50	**$9.00**	2.5%
24	Diagnosis and Treatment of Mental or Nervous Conditions	38a-488a; 38a-514	$10.55	$2.05	**$8.50**	$1.70	**$10.20**	2.8%
25	Accidental Ingestion or Consumption of Controlled Drugs	38a-492; 38a-518	$0.03	$0.00	**$0.03**	$0.01	**$0.04**	0.0%
26	Denial of Coverage - Persons with an Elevated Blood Alcohol Content	38a-498c; 38a-525c	$0.04	$0.01	**$0.03**	$0.01	**$0.04**	0.0%
27	Medical Complications of Alcoholism	38a-533 (grp only)	$0.40	$0.03	**$0.37**	$0.07	**$0.44**	0.1%
28	Occupational Therapy	38a-496; 38a-524	$1.59	$0.73	**$0.86**	$0.17	**$1.03**	0.3%
29	Physician Assistants and Certain Nurses	38a-499; 38a-526						
30	Services Provided by the Veterans' Home	38a-502; 38a-529	$0.45	$0.12	**$0.33**	$0.07	**$0.40**	0.1%
31	Direct Access to Obstetrician-Gynecologist	38a-503b; 38a-530b						
32	Chiropractic Services	38a-507; 38a-534	$3.55	$1.01	**$2.53**	$0.51	**$3.05**	0.8%
33	Experimental Treatments	38a-483c; 38a-513b	$0.01	$0.00	**$0.01**	$0.00	**$0.01**	0.0%
34	Hypodermic Needles and Syringes	38a-492a; 38a-518a	$0.09	$0.04	**$0.05**	$0.01	**$0.06**	0.0%
35	Certain Prescription Drugs Removed from Formulary	38a-492f; 38a-518f	$0.00	$0.00	**$0.00**	$0.00	**$0.00**	0.0%
36	Home Health Care	38a-493; 38a-520	$1.60	$0.13	**$1.47**	$0.29	**$1.76**	0.5%
37	Ambulance Services	38a-498; 38a-525	$2.36	$0.09	**$2.27**	$0.46	**$2.73**	0.8%
38	Comprehensive Rehabilitation Services (mandatory offer)	38a-523 (grp only)	$3.93	$1.52	**$2.42**	$0.48	**$2.90**	0.8%
39	Prescription Drug Coverage. Mail Order Pharmacies	38a-510; 38a-544	$0.00	$0.00	**$0.00**	$0.00	**$0.00**	0.0%
40	Co-payments re In-Network Imaging Services	38a-511; 38a-550	$0.00	-$1.00	**$1.00**	$0.20	**$1.20**	0.3%
41	Coverage for off-label cancer drugs	38a-492b; 38a-518b	**n/a**	**n/a**	**$2.86**	$0.57	**$3.43**	1.0%
42	Pain Management	38a-492i; 38a-518i	$0.00	$0.00	**$0.00**	$0.00	**$0.00**	0.0%
43	Cancer Clinical Trials	38a-504a-g; 38a-542a-g	$0.00	$0.00	**$0.00**	$0.00	**$0.00**	0.0%
44	Mobile Field Hospital	38a-498b; 38a-525b	$0.00	$0.00	**$0.00**	$0.00	**$0.00**	0.0%
45	Policy termination re maternity	38a-547 (grp only)	$0.00	$0.00	**$0.00**	$0.00	**$0.00**	0.0%
	TOTAL USING NET NEW COST FOR 13 & 14		$74.17	$11.27	**$65.75**	$13.16	**$78.92**	21.9%

Cost Share & Allowed not available for mandate # 41

APPENDIX TWO
GROUP COVERAGE

PROJECTED COSTS 2010 - 2014 **MEDICAL (PAID) COST ONLY**

	Mandate	Citation	2010	2011	2012	2013	2014
1	Orthodontic Treatment for Craniofacial Disorders	38a-490c; 38a-516c	**$0.02**	$0.02	$0.02	$0.02	$0.02
2	Inpatient Dental	38a-491a; 38a-517a	**$0.05**	$0.05	$0.06	$0.06	$0.06
3	Diabetes Testing and Treatment	38a-492d; 38a-518d	**$4.60**	$4.83	$5.07	$5.33	$5.59
4	Diabetes Outpatient Self-Management Training	38a-492e; 38a-518e	**$0.06**	$0.06	$0.07	$0.07	$0.07
5	Screening for Prostate Cancer	38a-492g; 38a-518g	**$0.19**	$0.20	$0.21	$0.22	$0.23
6	Lyme Disease Treatment	38a-492h; 38a-518h	**$0.28**	$0.29	$0.31	$0.32	$0.34
7	Ostomy Appliances and Supplies	38a-492j; 38a-518j	**$0.06**	$0.06	$0.07	$0.07	$0.07
8	Colorectal Cancer Screening	38a-492k; 38a-518k	**$3.40**	$4.07	$4.27	$4.49	$4.71
9	Tumors and Leukemia, etc	38a-504; 38a-542	**$11.00**	$11.55	$12.13	$12.73	$13.37
10	Birth-to-Three Program	38a-490a; 38a-516a	**$0.22**	$0.23	$0.24	$0.25	$0.27
11	Hearing Aids for Children 12 and under	38a-490b; 38a-516b	**$0.01**	$0.01	$0.01	$0.01	$0.01
12	Mammography and breast ultrasound	38a-503; 38a-530	**$2.54**	$2.80	$2.94	$3.08	$3.24
13	Maternity care and postpartum care (48/96 hours) net new cost only	38a-503c; 38a-530c	**$1.85**	$1.94	$2.04	$2.14	$2.25
14	Mastectomy or lymph node dissection (48 hours) net new cost	38a-503d; 38a-530d	**$0.10**	$0.11	$0.11	$0.12	$0.12
15	Prescription contraceptives	38a-503e; 38a-530e	**$1.20**	$1.26	$1.32	$1.39	$1.46
16	Infertility diagnosis and treatment	38a-509; 38a-536	**$2.80**	$2.94	$3.09	$3.24	$3.40
17	Autism Spectrum Disorder Therapies	38a-488b; 38a-514b	**$0.03**	$0.03	$0.03	$0.03	$0.04
18	Coverage for Newborn Infants	38a-490; 38a-516	**$4.96**	$5.21	$5.47	$5.74	$6.03
19	Blood Lead Screening and Risk Assessment	38a-490d	**$0.01**	$0.01	$0.01	$0.01	$0.01
20	Preventive Pediatric Care --Group Only, Excludes Blood Lead Test	38a-535	**$1.91**	$2.08	$2.18	$2.29	$2.40
21	Low Protein Modified Food Products, Amino Acid Modified Preparations, etc	38a-492c; 38a-518c	**$0.24**	$0.25	$0.26	$0.28	$0.29
22	Neuropsychological Testing for Children Diagnosed with Cancer	38a-492l; 38a-516d	**$0.00**	$0.00	$0.00	$0.00	$0.00
23	Standards re Psychotropic Drug Availability in Health Plans	38a-476b; 38a-476b	**$7.50**	$8.06	$8.67	$9.32	$10.02
24	Diagnosis and Treatment of Mental or Nervous Conditions	38a-488a; 38a-514	**$8.50**	$8.93	$9.37	$9.84	$10.33
25	Accidental Ingestion or Consumption of Controlled Drugs	38a-492; 38a-518	**$0.03**	$0.03	$0.03	$0.03	$0.04
26	Denial of Coverage - Persons with an Elevated Blood Alcohol Content	38a-498c; 38a-525c	**$0.03**	$0.03	$0.03	$0.03	$0.04
27	Medical Complications of Alcoholism	38a-533	**$0.37**	$0.39	$0.41	$0.43	$0.45
28	Occupational Therapy	38a-496; 38a-524	**$0.86**	$0.90	$0.95	$1.00	$1.05
29	Physician Assistants and Certain Nurses	38a-499; 38a-526		$0.00	$0.00	$0.00	$0.00
30	Services Provided by the Veterans' Home	38a-502; 38a-529	**$0.33**	$0.35	$0.36	$0.38	$0.40
31	Direct Access to Obstetrician-Gynecologist	38a-503b; 38a-530b		$0.00	$0.00	$0.00	$0.00
32	Chiropractic Services	38a-507; 38a-534	**$2.53**	$2.66	$2.79	$2.93	$3.08
33	Experimental Treatments	38a-483c; 38a-513b	**$0.01**	$0.01	$0.01	$0.01	$0.01
34	Hypodermic Needles and Syringes	38a-492a; 38a-518a	**$0.05**	$0.05	$0.06	$0.06	$0.06
35	Certain Prescription Drugs Removed from Formulary	38a-492f; 38a-518f	**$0.00**	$0.00	$0.00	$0.00	$0.00
36	Home Health Care	38a-493; 38a-520	**$1.47**	$1.54	$1.62	$1.70	$1.79
37	Ambulance Services	38a-498; 38a-525	**$2.27**	$2.38	$2.50	$2.63	$2.76
38	Comprehensive Rehabilitation Services (mandatory offer)	38a-523 (grp only)	**$2.42**	$2.54	$2.66	$2.80	$2.94
39	Prescription Drug Coverage. Mail Order Pharmacies	38a-510; 38a-544	**$0.00**	$0.00	$0.00	$0.00	$0.00
40	Co-payments re In-Network Imaging Services	38a-511; 38a-550	**$1.00**	$1.05	$1.10	$1.16	$1.22
41	Coverage for off-label cancer drugs	38a-492b; 38a-518b	**$2.86**	$3.00	$3.15	$3.31	$3.48
42	Pain Management	38a-492i; 38a-518i	**$0.00**	$0.00	$0.00	$0.00	$0.00
43	Cancer Clinical Trials	38a-504a-g; 38a-542a-g	**$0.00**	$0.00	$0.00	$0.00	$0.00
44	Mobile Field Hospital	38a-498b; 38a-525b	**$0.00**	$0.00	$0.00	$0.00	$0.00
45	Policy termination re maternity	38a-547 (grp only)	**$0.00**	$0.00	$0.00	$0.00	$0.00
	TOTAL USING NET NEW COST FOR MANDATES 13 & 14		**$65.75**	**$69.93**	**$73.63**	**$77.53**	**$81.64**

Appendix Two (Continued)

ASSUMPTIONS for 5 Year Cost Projection:

Cost Increase in 2011 for Mandates 8, 10, and 20 Reflects the Elimination of Member Cost Sharing for Preventive Services under PPACA

All mandates expected to increase at 5% annually except:

Mandate 23, Psychotropic Drugs, projected to increase 7.5% annually

Note that Mandate 17, Autism Spectrum Disorder, will include behavioral therapy going forward, but that additional cost has not been included in the 2010 to 2014 medical cost of this mandate because it was unavailable from the 2007 - 2009 carrier data. During 2009, only PT/OT/ST were covered by the autism spectrum mandate. Beginning in 2010, psychiatric, psychological, and other behavioral services were added to this mandate.

APPENDIX THREE
INDIVIDUAL COVERAGE PLANS
PROJECTED 2010 COSTS

NOTE: Individual data is less credible than group data primarily due to small sample size

			PMPM AMOUNTS					
					= A - B		=C + D	
			A	B	C	D	E	F
			ALLOWED	COST SHARE	**PAID**	RETENTION	**PAID + RETENTION**	% of PREMIUM
1	Orthodontic Treatment for Craniofacial Disorders	38a-490c; 38a-516c	$0.03	$0.00	**$0.03**	$0.01	**$0.04**	0.0%
2	Inpatient Dental	38a-491a; 38a-517a	$0.20	$0.02	**$0.19**	$0.06	**$0.24**	0.1%
3	Diabetes Testing and Treatment	38a-492d; 38a-518d	$0.70	$0.14	**$0.56**	$0.17	**$0.73**	0.3%
4	Diabetes Outpatient Self-Management Training	38a-492e; 38a-518e	$0.02	$0.00	**$0.02**	$0.01	**$0.03**	0.0%
5	Screening for Prostate Cancer	38a-492g; 38a-518g	$0.19	$0.08	**$0.11**	$0.03	**$0.14**	0.1%
6	Lyme Disease Treatment	38a-492h; 38a-518h	$0.46	$0.12	**$0.34**	$0.10	**$0.44**	0.2%
7	Ostomy Appliances and Supplies	38a-492j; 38a-518j	$0.02	$0.00	**$0.02**	$0.01	**$0.03**	0.0%
8	Colorectal Cancer Screening	38a-492k; 38a-518k	$2.26	$0.57	**$1.68**	$0.50	**$2.19**	0.8%
9	Tumors and Leukemia, etc	38a-504; 38a-542	$10.12	$1.52	**$8.60**	$2.57	**$11.17**	4.1%
10	Birth-to-Three Program	38a-490a; 38a-516a	$0.26	$0.01	**$0.25**	$0.08	**$0.33**	0.1%
11	Hearing Aids for Children 12 and under	38a-490b; 38a-516b	$0.01	$0.00	**$0.01**	$0.00	**$0.01**	0.0%
12	Mammography and breast ultrasound	38a-503; 38a-530	$2.33	$0.44	**$1.88**	$0.56	**$2.45**	0.9%
13	Maternity care and postpartum care (48/96 hours), (net new cost)	38a-503c; 38a-530c	$1.44	$0.16	**$1.28**	$0.38	**$1.66**	0.6%
14	Mastectomy or lymph node dissection (48 hours), (net new cost)	38a-503d; 38a-530d	$0.08	$0.01	**$0.07**	$0.02	**$0.09**	0.0%
15	Prescription contraceptives	38a-503e; 38a-530e	$1.98	$1.04	**$0.94**	$0.28	**$1.22**	0.4%
16	Infertility diagnosis and treatment	38a-509; 38a-536	$1.57	$0.18	**$1.39**	$0.42	**$1.81**	0.7%
17	Autism Spectrum Disorder Therapies	38a-488b; 38a-514b	$0.01	$0.00	**$0.00**	$0.00	**$0.00**	0.0%
18	Coverage for Newborn Infants	38a-490; 38a-516	$4.13	$0.17	**$3.96**	$1.18	**$5.14**	1.9%
19	Blood Lead Screening and Risk Assessment	38a-490d	$0.01	$0.01	**$0.00**	$0.00	**$0.00**	0.0%
20	Preventive Pediatric Care	38a-535 Grp Only						
21	Low Protein Modified Food Products, Amino Acid Modified Preparations, etc	38a-492c; 38a-518c	$0.09	$0.01	**$0.08**	$0.02	**$0.11**	0.0%
22	Neuropsychological Testing for Children Diagnosed with Cancer	38a-492l; 38a-516d	$0.00	$0.00	**$0.00**	$0.00	**$0.00**	0.0%
23	Standards re Psychotropic Drug Availability in Health Plans	38a-476b; 38a-476b	$6.54	$2.56	**$3.98**	$1.19	**$5.16**	1.9%
24	Diagnosis and Treatment of Mental or Nervous Conditions	38a-488a; 38a-514	$7.53	$1.93	**$5.60**	$1.67	**$7.27**	2.7%
25	Accidental Ingestion or Consumption of Controlled Drugs	38a-492; 38a-518	$0.03	$0.00	**$0.02**	$0.01	**$0.03**	0.0%
26	Denial of Coverage - Persons with an Elevated Blood Alcohol Content	38a-498c; 38a-525c	$0.13	$0.03	**$0.10**	$0.03	**$0.13**	0.0%
27	Medical Complications of Alcoholism	38a-533 Grp ONLY						
28	Occupational Therapy	38a-496; 38a-524	$0.57	$0.15	**$0.42**	$0.13	**$0.54**	0.2%
29	Physician Assistants and Certain Nurses	38a-499; 38a-526						
30	Services Provided by the Veterans' Home	38a-502; 38a-529	$0.29	$0.15	**$0.14**	$0.04	**$0.18**	0.1%
31	Direct Access to Obstetrician-Gynecologist	38a-503b; 38a-530b						
32	Chiropractic Services	38a-507; 38a-534	$2.47	$1.24	**$1.23**	$0.37	**$1.60**	0.6%
33	Experimental Treatments	38a-483c; 38a-513b	$0.00	$0.00	**$0.00**	$0.00	**$0.00**	0.0%
34	Hypodermic Needles and Syringes	38a-492a; 38a-518a	$0.07	$0.06	**$0.01**	$0.00	**$0.01**	0.0%
35	Certain Prescription Drugs Removed from Formulary	38a-492f; 38a-518f	$0.00	$0.00	**$0.00**	$0.00	**$0.00**	0.0%
36	Home Health Care	38a-493; 38a-520	$0.82	$0.07	**$0.75**	$0.22	**$0.97**	0.4%
37	Ambulance Services	38a-498; 38a-525	$1.47	$0.23	**$1.25**	$0.37	**$1.62**	0.6%
38	Comprehensive Rehabilitation Services (mandatory offer)	38a-523 Grp ONLY						
39	Prescription Drug Coverage. Mail Order Pharmacies	38a-510; 38a-544	$0.00	$0.00	**$0.00**	$0.00	**$0.00**	0.0%
40	Co-payments re In-Network Imaging Services	38a-511; 38a-550	$0.00	($0.69)	**$0.69**	$0.21	**$0.90**	0.3%
41	Coverage for off-label drug prescriptions (cancer)	38a-492b; 38a-518b	**n/a**	**n/a**	**$1.91**	$0.57	**$2.48**	0.9%
42	Pain Management	38a-492i; 38a-518i	$0.00	$0.00	**$0.00**	$0.00	**$0.00**	0.0%
43	Cancer Clinical Trials	38a-504a-g; 38a-542a-g	$0.00	$0.00	**$0.00**	$0.00	**$0.00**	0.0%
44	Mobile Field Hospital	38a-498b; 38a-525b	$0.00	$0.00	**$0.00**	$0.00	**$0.00**	0.0%
45	Policy termination re maternity	38a-547	$0.00	$0.00	**$0.00**	$0.00	**$0.00**	0.0%
	TOTAL USING NET NEW COST FOR 13 & 14		$45.83	$10.21	**$37.53**	$11.21	**$48.74**	17.9%

\# Cost Share and Allowed are not available for mandate # 41

APPENDIX FOUR

GROUP + INDIVIDUAL COVERAGE
PROJECTED 2010 COSTS

TOTAL COST CALCULATION
BASED ON **1,393,444**
TOTAL INSUREDS

			ALLOWED	ALLOWED + RETENTION	All Insureds Medical Cost Only (PAID)	State EEs Plan Medical Cost Only (PAID)	All - State EEs Medical Cost Only (PAID)
1	Orthodontic Treatment for Craniofacial Disorders	38a-490c; 38a-516c	$ 381,009	$ 460,045	$ 361,394	$ 39,440	$ 321,954
2	Inpatient Dental	38a-491a; 38a-517a	$ 1,241,285	$ 1,503,625	$ 1,120,260	$ 98,600	$ 1,021,659
3	Diabetes Testing and Treatment	38a-492d; 38a-518d	$ 81,281,593	$ 95,104,374	$ 68,539,591	$ 9,071,237	$ 59,468,354
4	Diabetes Outpatient Self-Management Training	38a-492e; 38a-518e	$ 1,032,614	$ 1,222,009	$ 924,452	$ 118,320	$ 806,132
5	Screening for Prostate Cancer	38a-492g; 38a-518g	$ 3,549,247	$ 4,173,989	$ 3,011,100	$ 374,682	$ 2,636,418
6	Lyme Disease Treatment	38a-492h; 38a-518h	$ 6,062,137	$ 7,093,658	$ 4,808,510	$ 552,162	$ 4,256,348
7	Ostomy Appliances and Supplies	38a-492j; 38a-518j	$ 1,101,244	$ 1,290,639	$ 924,452	$ 118,320	$ 806,132
8	Colorectal Cancer Screening	38a-492k; 38a-518k	$ 61,791,095	$ 72,793,836	$ 53,290,764	$ 6,704,827	$ 46,585,936
9	Tumors and Leukemia, etc	38a-504; 38a-542	$ 199,237,485	$ 236,790,751	$ 178,960,187	$ 21,692,088	$ 157,268,099
10	Birth-to-Three Program	38a-490a; 38a-516a	$ 3,985,825	$ 4,787,056	$ 3,747,147	$ 433,842	$ 3,313,306
11	Hearing Aids for Children 12 and under	38a-490b; 38a-516b	$ 176,635	$ 212,745	$ 169,288	$ 19,720	$ 149,568
12	Mammography and breast ultrasound	38a-503; 38a-530	$ 44,003,538	$ 52,611,561	$ 41,111,390	$ 5,008,900	$ 36,102,490
13	Maternity care and postpartum care (48/96 hours))net new cost)	38a-503c; 38a-530c	$ 31,841,582	$ 38,054,067	$ 29,752,047	$ 3,648,215	$ 26,103,832
14	Mastectomy or lymph node dissection (48 hours)	38a-503d; 38a-530d	$ 1,777,114	$ 2,113,426	$ 1,609,901	$ 197,201	$ 1,412,700
15	Prescription contraceptives	38a-503e; 38a-530e	$ 36,553,331	$ 40,651,203	$ 19,526,785	$ 2,366,410	$ 17,160,376
16	Infertility diagnosis and treatment	38a-509; 38a-536	$ 47,674,061	$ 56,738,633	$ 43,898,201	$ 5,521,622	$ 38,376,579
17	Autism Spectrum Disorder Therapies	38a-488b; 38a-514b	$ 585,264	$ 673,912	$ 441,972	$ 59,160	$ 382,812
18	Coverage for Newborn Infants	38a-490; 38a-516	$ 83,171,804	$ 100,154,997	$ 80,862,446	$ 9,781,160	$ 71,081,286
19	Blood Lead Screening and Risk Assessment	38a-490d	$ 187,202	$ 218,163	$ 152,049	$ 19,720	$ 132,329
20	Preventive Pediatric Care --Group Only, Excludes Blood Lead Test	38a-535	$ 29,052,573	$ 34,647,698	$ 27,975,625	$ 3,766,535	$ 24,209,090
21	Low Protein Modified Food Products, Amino Acid Modified Preparations, etc	38a-492c; 38a-518c	$ 3,773,871	$ 4,527,074	$ 3,683,157	$ 473,282	$ 3,209,875
22	Neuropsychological Testing for Children Diagnosed with Cancer	38a-492l; 38a-516d	$ 8,155	$ 9,732	$ 5,277	$ -	$ 5,277
23	Standards re Psychotropic Drug Availability in Health Plans	38a-476b; 38a-476b	$ 154,945,785	$ 179,380,357	$ 118,101,595	$ 14,790,060	$ 103,311,535
24	Diagnosis and Treatment of Mental or Nervous Conditions	38a-488a; 38a-514	$ 170,087,665	$ 198,456,968	$ 136,114,245	$ 16,762,068	$ 119,352,177
25	Accidental Ingestion or Consumption of Controlled Drugs	38a-492; 38a-518	$ 532,698	$ 635,632	$ 489,800	$ 59,160	$ 430,640
26	Denial of Coverage - Persons with an Elevated Blood Alcohol Content	38a-498c; 38a-525c	$ 803,324	$ 952,409	$ 644,304	$ 59,160	$ 585,144
27	Medical Complications of Alcoholism	38a-533	$ 5,841,636	$ 6,925,508	$ 5,419,362	$ 729,643	$ 4,689,719
28	Occupational Therapy	38a-496; 38a-524	$ 24,520,018	$ 27,298,980	$ 13,465,755	$ 1,695,927	$ 11,769,828
29	Physician Assistants and Certain Nurses	38a-499; 38a-526	$ -	$ -	$ -	$ -	$ -
30	Services Provided by the Veterans' Home	38a-502; 38a-529	$ 7,201,847	$ 8,255,382	$ 5,124,204	$ 650,763	$ 4,473,442
31	Direct Access to Obstetrician-Gynecologist	38a-503b; 38a-530b	$ -	$ -	$ -	$ -	$ -
32	Chiropractic Services	38a-507; 38a-534	$ 57,170,178	$ 65,373,895	$ 39,611,374	$ 4,989,180	$ 34,622,194
33	Experimental Treatments	38a-483c; 38a-513b	$ 96,911	$ 113,392	$ 82,242	$ 11,073	$ 71,169
34	Hypodermic Needles and Syringes	38a-492a; 38a-518a	$ 1,487,254	$ 1,638,333	$ 746,795	$ 98,600	$ 648,194
35	Certain Prescription Drugs Removed from Formulary	38a-492f; 38a-518f	$ 29,921	$ 35,917	$ 29,921	$ 4,028	$ 25,892
36	Home Health Care	38a-493; 38a-520	$ 25,068,547	$ 29,848,475	$ 23,088,061	$ 2,898,852	$ 20,189,209
37	Ambulance Services	38a-498; 38a-525	$ 37,624,143	$ 45,063,255	$ 35,852,109	$ 4,478,667	$ 31,373,443
38	Comprehensive Rehabilitation Services (mandatory offer)	38a-523	$ 57,593,213	$ 64,685,155	$ 35,388,791	$ 4,764,617	$ 30,624,175
39	Prescription Drug Coverage. Mail Order Pharmacies	38a-510; 38a-544	$ -	$ -	$ -	$ -	$ -
40	Co-payments re In-Network Imaging Services	38a-511; 38a-550	$ -	$ 3,364,365	$ 16,083,509	$ 1,972,008	$ 14,111,501
41	Coverage for off-label drug prescriptions (cancer)	38a-492b; 38a-518b	n/a	n/a	$ 45,844,017	$ 5,639,943	$ 40,204,074
42	Pain Management	38a-492i; 38a-518i	$ -	$ -	$ -	$ -	$ -
43	Cancer Clinical Trials	38a-504a-g; 38a-542a-g	$ -	$ -	$ -	$ -	$ -
44	Mobile Field Hospital	38a-498b; 38a-525b	$ -	$ -	$ -	$ -	$ -
45	Policy termination re maternity	38a-547	$ -	$ -	$ -	$ -	$ -
	TOTAL USING Net New Cost FOR 13 & 14. Note--Mandate 41--no Allowed Cost available		$ 1,181,471,807	$ 1,387,861,214	**$ 1,040,962,080**	$ 129,669,193	$ 911,292,887

Based on 1,220,577 Group Insured people and 172,867 Individual Insured

State Employees (EEs) Cost Calculated Using 164,334 covered lives times group paid cost PMPM times 12 months--this assumes state employees' average mandate cost is same as average cost for all groups in CT

APPENDIX FIVE
SELF FUNDED SURVEY
SIX CARRIERS

Citation	Description	Total Members	Number of Members Covered by Mandate	% of Members Covered by Mandate	# Responses
SET ONE					
38a-490c and 38a-516c	Craniofacial Disorders	863,279	591,618	**68.5%**	6
38a-491a and 38a-517a	Coverage for Inpatient Dental	413,290	245,237	**59.3%**	5
38a-492d and 38a-518d	Coverage for Diabetes	413,290	363,388	**87.9%**	5
38a-492e and 38a-518e	Diabetes Outpatient Self-Management Training	413,290	241,833	**58.5%**	5
38a-492g and 38a-518g	Screening for Prostate Cancer	413,290	393,974	**95.3%**	5
38a-492h and 38a-518h	Lyme Disease Treatment	413,290	371,922	**90.0%**	5
38a-492j and 38a-518j	Ostomy Appliances and Supplies	413,290	190,292	**46.0%**	5
38a-492k and 38a-518k	Colorectal Cancer Screening	413,290	406,511	**98.4%**	5
38a-504 and 38a-542	Tumors and Leukemia/Breast Implant Removal & Reconstruction	413,290	355,797	**86.1%**	5
38a-490b and 38a-516b	Hearing Aids for Children 12 and Younger	863,279	503,950	**58.4%**	6
38a-490a and 38a-516a	Birth-To-Three Program (Early Intervention Services)	413,290	105,250	**25.5%**	5
SET TWO					
38a-503 and 38a-530	Mammography/Breast Cancer Screening	413,290	395,215	**95.6%**	5
38a-503c and 38a-530c	Maternity Care & Postpartum Care (48/96 hours)	413,290	385,977	**93.4%**	5
38a-503d and 38a-530d	Mastectomy or Lymph Node Dissection (48 hours)	413,290	343,002	**83.0%**	5
38a-503e and 38a-530e	Prescription Birth Control	863,279	563,105	**65.2%**	6
38a-509 and 38a-536	Infertility Treatment & Procedures	413,290	308,553	**74.7%**	5
38a-488b and 38a-514b	Coverage for Autism Spectrum Disorder	413,290	105,175	**25.4%**	5
38a-490 and 38a-516	Coverage for newborn infants in health insurance policies	413,290	366,890	**88.8%**	5
38a-490d (Indiv only)	Mandatory Coverage for blood lead screening and risk assessment	413,290	402,396	**97.4%**	5
38a-535 (Group only)	Pediatric Preventive Care and Blood Lead Screening	413,290	402,396	**97.4%**	5
38a-492c and 38a-518c	Coverage for Prescription Foods/Formula	863,279	90,791	**10.5%**	6
38a-492l and 38a-516d	Developmental Needs of Children & Youth with Cancer	413,290	95,178	**23.0%**	5
SET THREE					
38a-476b	Psychotropic Drug Availability	413,290	293,701	**71.1%**	5
38a-488a and 38a-514	Mental or Nervous Conditions	413,890	372,112	**89.9%**	5
38a-492 and 38a-518	Accidental Ingestion of Controlled Drug	413,290	397,473	**96.2%**	5
38a-498c and 38a-525c	Denial of Coverage Prohibited for Health Services to People with Elevated Blood Alcohol Content	413,290	381,289	**92.3%**	5
38a-533 (Group only)	Coverage for Treatment of Medical Complications of Alcoholism	413,290	390,648	**94.5%**	5
38a-496 and 38a-524	Coverage for Occupational Therapy	413,290	392,670	**95.0%**	5
38a-499 and 38a-526	Mandatory Coverage for Physician Assistants and Certain Nurses	413,290	318,149	**77.0%**	5
38a-502 and 38a-529	Mandatory Coverage for Services Provided by the Veterans' Home	413,290	294,875	**71.3%**	5
38a-503b and 38a-530b	Permit Direct Access to OB/GYNs	413,290	401,992	**97.3%**	5
38a-507 and 38a-534	Mandatory Coverage for Chiropractic Services	413,290	355,579	**86.0%**	5
SET FOUR					
38a-483c and 38a-513b	Experimental Treatments	395,451 N	64,656	**16.3%**	5
38a-492a and 38a-518a	Hypodermic Needles and Syringes	413,290	357,595	**86.5%**	5
38a-492f and 38a-518f	Drugs Removed From Formulary	413,290	82,261	**19.9%**	5
38a-493 and 38a-520	Home Health Care	413,290	372,424	**90.1%**	5
38a-498 and 38a-525	Ambulance Services	863,279	814,181	**94.3%**	6
38a-510 and 38a-544	Prohibit Requiring Mail Order Prescription Drugs	413,290	267,593	**64.7%**	5
38a-511 and 38a-550	Access to Imaging Services	413,290	388,036	**93.9%**	5
38a-523 (Group only)	Comprehensive Rehabilitation Services (mandatory offer)	413,290	325,789	**78.8%**	5
				71.9%	35 5 COUNT

Appendix III

Glossary of Terms and Acronyms

Term	Definition
Administrative services only (ASO) contract	A contract between an insurance company or third party administrator (TPA) and a self-funded plan according to which the insurance company or TPA performs administrative services only and does not assume any risk. The services usually include claims processing but may include other services as well, such as actuarial analysis, utilization review, and so forth.
Alcoholism	A chronic progressive potentially fatal psychological and nutritional disorder associated with excessive and usually compulsive drinking of alcohol and characterized by frequent intoxication leading to dependence on or addiction to the substance, impairment of the ability to work and socialize, destructive behaviors (as drunken driving), tissue damage (as cirrhosis of the liver), and severe withdrawal symptoms upon detoxification.
Amino acid modified preparation	A product intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.
Autism Spectrum Disorder (ASD)	A developmental disorder that appears by age three and that is variable in expression but is recognized and diagnosed by impairment of the ability to form normal social relationships, by impairment of the ability to communicate with others, and by stereotyped behavior patterns especially as exhibited by a preoccupation with repetitive activities of restricted focus rather than with flexible and imaginative ones.
Cancer clinical trial	An organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer in human beings.
CCEA	Connecticut Center for Economic Analysis.
Centers for Medicare & Medicaid Services (CMS)	The federal agency responsible for financing and overseeing Medicare and Medicaid services. CMS is part of the U.S. Department of Health and Human Services and was formerly known as the Health Care Financing Administration.
Chemotherapy	The use of chemical agents in the treatment or control of disease or mental disorder.
Children's Health Insurance Program (CHIP)	Also referred to as State Children's Health Insurance Program (SCHIP). A program created by the federal government to provide a "safety net" and preventive-care level of health coverage for children. The program is funded through a combination of federal and state funds and administered by the states in conformance with federal requirements.
Chiropractic	A system of therapy which holds that disease results from a lack of normal nerve function and which employs manipulation and specific adjustment of body structures (as the spinal column).
CID	Connecticut Insurance Department.
Cirrhosis	Widespread disruption of normal liver structure by fibrosis and the formation of regenerative nodules that is caused by any of various chronic progressive conditions affecting the liver (e.g. long-term alcohol abuse or hepatitis).

Term	Definition
Coinsurance	Refers to an insurance provision that limits the amount of coverage for services to a certain percentage, commonly 80 percent. The rest of the cost is paid by the member out of pocket.
Colorectal	Relating to or affecting the colon and the rectum.
Colorectal cancer	Cancer of the colon or rectum.
Colostomy	Surgical formation of an artificial anus by connecting the colon to an opening in the abdominal wall.
Complementary and alternative medicine (CAM)	Treatment modalities other than traditional allopathic medicine. Examples include acupuncture, chiropractic medicine, homeopathy, and various forms of "natural healing."
Computed Axial Tomography (CAT)	Radiography in which a three-dimensional image of a body structure is constructed by computer from a series of plane cross-sectional images made along an axis. Also known as Computed Tomography (CT).
Computed Tomography (CT)	See Computed Axial Tomography.
Conversion	The conversion of coverage under a group master contract to coverage under an individual contract. The chance to convert is offered to subscribers who lose their group coverage (e.g., through job loss or death of a working spouse) and who are ineligible for coverage under another group contract.
Co-payment	The amount that a member must pay out of pocket for medical services. It is usually a fixed amount, such as $10, $15 or $25 per service.
Cost sharing	Payment by a member of some portion of the cost of services. Usual forms of cost sharing include deductibles, coinsurance, and co-payments.
Cost-shifting	Raising the prices charged to other payers to cover the cost of providing services for which the reimbursement received does not fully cover the cost.
CPHHP	University of Connecticut Center for Public Health and Health Policy
Craniofacial	Of, relating to, or involving both the cranium and the face.
Deductible	That portion of a subscriber's (or member's) health care expenses that must be paid out of pocket before the insurance coverage applies ($100 to $1500 depending on type of plan). Deductibles are common in insurance plans and PPOs, uncommon in HMOs, and they may apply only to the out-of-network portion of a point-of-service plan or only to one portion of the plan coverage (e.g., just to pharmacy services).
Delirium tremens	A violent delirium with tremors that is induced by excessive and prolonged use of alcoholic liquors.

Term	Definition
Diabetes	A disorder of carbohydrate metabolism, usually occurring in genetically predisposed individuals, characterized by inadequate production or utilization of insulin and resulting in excessive amounts of glucose in the blood and urine, excessive thirst, weight loss, and in some cases progressive destruction of small blood vessels leading to such complications as infections and gangrene of the limbs or blindness. Also called diabetes mellitus.
Direct access	Access to specialists without requiring a referral from a primary care provider. In an HMO that uses the direct access model, a member may self-refer to a specialist rather than having to seek an authorization. In such HMOs, the co-payment for care received from a specialist may be higher than the co-pay for care received from a primary care provider.
Disease management	The process of intensively managing a particular disease, especially chronic diseases. Disease management differs from large case management in that it goes well beyond managing the care of a patient during a single hospital stay or treating an acute exacerbation of a condition. Instead, it encompasses all settings of care and places a heavy emphasis on prevention and maintenance. Disease management is commonly used for a defined set of diseases.
DPH	Connecticut Department of Public Health
Drug utilization review (DUR)	The tools and techniques to manage utilization of drugs. It is similar in concept to utilization management in general, but focuses strictly on pharmacy benefit use and cost.
DSS	Department of Social Services
Durable medical equipment (DME)	Medical equipment that is not disposable (i.e., is used repeatedly). Examples include wheelchairs, home hospital beds, and so forth. Durable medical equipment is an area of increasing expense, particularly in conjunction with case management.
Elevated blood alcohol content	A ratio of alcohol in the blood of such person that is eight-hundredths of one per cent or more of alcohol, by weight.
Emergency Medical Treatment and Active Labor Act (EMTALA)	An act passed in 1986 that dictates that all patients presenting to a hospital emergency department must have a medical screening exam performed by qualified personnel, usually an emergency physician. The medical screening exam cannot be delayed for insurance reasons, either to obtain insurance information or to obtain preauthorization for examination. The act states, "An emergency medical condition means a medical condition manifested by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in: a) placing the patient's health in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part."
Employee Retirement Income Security Act (ERISA)	The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans.

Term	Definition
Formulary	A listing of approved drugs that a physician may prescribe (e.g., a list of drugs approved for use within a specific health care setting). The physician is requested or required to use only formulary drugs unless there is a valid medical reason to use a nonformulary drug.
Gamete intra-fallopian transfer	An assisted reproductive procedure which involves removing a woman's eggs, mixing them with sperm and immediately placing them into her fallopian tube.
Gastrointestinal	Of, relating to, or affecting both stomach and intestine.
Group Coverage	A type of health insurance in which members receive coverage through an insurance contract that covers an entire group, usually an employer group. Employees usually have the option of covering other members of their families as well.
Health Care Center	The Connecticut statutory term for HMO.
Health Maintenance Organization (HMO)	A type of managed care plan that acts as both insurer and provider of a comprehensive set of health care services to an enrolled population. Services are furnished through a network of providers.
Hospital	An institution which is primarily engaged in providing, by or under the supervision of physicians, to inpatients (1) diagnostic, surgical and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, or (2) medical rehabilitation services for the rehabilitation of injured, disabled or sick persons.
Hypodermic syringe	A small syringe used with a hollow needle for injection of material into or beneath the skin.
IC	Ingenix Consulting
Ileostomy	Surgical formation of an artificial anus by connecting the ileum to an opening in the abdominal wall.
Individual Coverage	A type of health insurance in which there is a contract directly between an insurer and an individual who may purchase self-only coverage or may add other members of their family for additional premium cost.
Infertility	The condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period.
Intrauterine insemination	Also referred to as artificial insemination, is a procedure which involves placing sperm inside a woman's uterus to facilitate fertilization.
Lead poisoning	Chronic intoxication that is produced by the absorption of lead into the system and is characterized by fatigue, abdominal pain, nausea, diarrhea, loss of appetite, anemia, a dark line along the gums, and muscular paralysis or weakness of limbs.

Term	Definition
Leukemia	An acute or chronic disease of unknown cause in humans and other warm-blooded animals that involves the blood-forming organs, is characterized by an abnormal increase in the number of white blood cells in the tissues of the body with or without a corresponding increase of those in the circulating blood, and is classified according to the type of white blood cell most prominently involved.
Low protein modified food product	A product formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.
Lyme disease	An acute inflammatory disease that is usually characterized initially by the skin lesion erythema migrans and by fatigue, fever, and chills and if left untreated may later manifest itself in cardiac and neurological disorders, joint pain, and arthritis and that is caused by a spirochete of the genus *Borrelia* (*B. burgdorferi*) transmitted by the bite of a tick especially of the genus *Ixodes.*
Lymph node	Any of the rounded masses of lymphoid tissue that are surrounded by a capsule of connective tissue, are distributed along the lymphatic vessels, and contain numerous lymphocytes which filter the flow of lymph passing through the node.
Magnetic Resonating Image (MRI)	A noninvasive diagnostic technique that produces computerized images of internal body tissues and is based on nuclear magnetic resonance of atoms within the body induced by the application of radio waves.
Mammography	X-ray examination of the breasts (as for early detection of cancer).
Managed care	Managed care is a system of health care delivery that tries to control costs of health care services while regulating access to those services and maintaining or improving their quality.
Managed care organization (MCO)	An organization that delivers health care services using a managed care approach. Some people prefer managed care organization to health maintenance organization because it encompasses plans that do not conform to the strict definition of an HMO. Managed care organizations include preferred provider organizations, point-of-service plans, integrated delivery systems, open-panel HMOs, and closed-panel HMOs.
Mandated benefits	Benefits that a health plan is required to provide according to state and federal law(s). Self-funded plans are exempt from state mandated benefits under ERISA.
Mastectomy	Surgical removal of all or part of the breast and sometimes associated lymph nodes.
MCO	Managed Care Organization
Medical complications of alcoholism	Such diseases as cirrhosis of the liver, gastrointestinal bleeding, pneumonia, and delirium tremens.

Term	Definition
Medical cost ratio (MCR)	The ratio between the total cost of delivering medical care and the total amount of money taken in by the insurer in the form of premium. The medical cost ratio is dependent on the amount of money brought in as well as the cost of delivering care; thus, if premium rates are too low, the ratio may be high even though the cost of delivering care is not within the general parameters of the cost of case.
Medical trend	The change in the cost of medical care driven by changes in utilization and unit costs of covered services.
Member	An individual covered under a managed care plan. Members include subscribers and dependents.
Member month	One month of coverage for one member. For example, if a plan had 10,000 members in January and 12,000 members in February, the total member months for the year to date as of March 1 would be 22,000.
Midlevel practitioners (MLPs)	Nonphysician medical care providers who generally deliver care under the supervision of a physician or in coordination with a physician. For example, physician assistants, nurse practitioners, nurse midwives.
Mobile field hospital	An organization of medical personnel with equipment for establishing a temporary hospital in the field.
Neuropsychology	A science concerned with the integration of psychological observations on behavior and the mind with neurological observations on the brain and nervous system.
Off-label	Of, relating to, or being an approved drug legally prescribed or a medical device legally used by a physician for a purpose (as the treatment of children or of a certain disease or condition) for which it has not been specifically approved (as by the United States Food and Drug Administration).
Ostomate	A person who has undergone ostomy surgery.
Ostomy	A surgically created opening in the body that allows for the discharge of bodily wastes.
Ovulation induction	The stimulation of the follicles in ovaries which results in the production of multiple eggs in one cycle. Ovulation induction medications (sometimes referred to as fertility drugs) also control the time of ovulate, so sexual intercourse, intrauterine inseminations, and in vitro fertilization procedures can be scheduled at the most likely time to achieve pregnancy.
Pain	A sensation in which a person experiences severe discomfort, distress or suffering due to provocation of sensory nerves.
Pain management specialist	A physician who is credentialed by the American Academy of Pain Management or who is a board-certified anesthesiologist, neurologist, oncologist or radiation oncologist with additional training in pain management.

Term	Definition
Pap smear test	A method or a test used for the early detection of cancer, especially of the uterine cervix, that involves staining exfoliated cells by a special technique which differentiates diseased tissue.
Partial hospitalization	A formal program of care provided in a hospital or facility for periods of less than twenty-four hours a day.
Per member per month (PMPM)	Specifically applies to revenue or cost for each enrolled member each month.
Positron Emission Tomography (PET)	Tomography in which an in vivo, noninvasive, cross-sectional image of regional metabolism is obtained by a usually color-coded cathode-ray tube representation of the distribution of gamma radiation given off in the collision of electrons in cells with positrons emitted by radionuclides incorporated into metabolic substances.
Premium Rate	The amount of money that a group or an individual must pay to a health plan for coverage. The payment is usually in the form of a monthly fee. The term rating refers to the development of rates by a health plan.
Preventive care	Health care that is aimed at preventing complications of existing diseases or preventing the occurrence of diseases.
Prostate specific antigen	A protease that is secreted by the epithelial cells of the prostate and is used in the diagnosis of prostate cancer since its concentration in the blood serum tends to be proportional to the clinical stage of the disease.
Prosthesis	An artificial device to replace or augment a missing or impaired part of the body.
Psychotropic drug	Any drug capable of affecting the mind, emotions, and behavior.
Rehabilitative agency	An agency which provides an integrated multi-treatment program designed to improve the function of individuals disabled by disease or injury by bringing together, as a team, specialized personnel from various allied health fields.
Self-funded plan	In a self-funded plan, the risk for medical cost is assumed by the employer rather than an insurance company or managed care plan. Under the Employee Retirement Income Security Act, self-funded plans are exempt from state laws and regulations. They are also exempt from premium taxes. Self-funded plans often contract with insurance companies or third-party administrators to administer benefits.
Self-insured plans	See self-funded plan.
Stoma	The end of the ureter or small or large bowel that protrudes through the abdominal wall allowing passage of bodily wastes.
Specialized formula	A nutritional formula for children up to age twelve that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal Food and Drug Administration and is intended for use solely under medical supervision in the dietary management of specific diseases.

Term	Definition
State of domicile	The state in which an insurance company or MCO is licensed as its primary location. For example, the state of domicile for an insurer may be Virginia, but the insurer might also be licensed and doing business in Maryland and the District of Columbia. MCOs, on the other hand, because of their local networks, are domiciled and licensed in a single state. The unique nature of their local service delivery requires them to be domiciled in each market they operate in. In many states, the insurance commissioner will defer primary regulation of an insurance company to the insurance department in the state of domicile as long as all minimum standards of the state are met.
Subscriber	The individual or member who has the health plan coverage in virtue of being eligible on his or her own behalf rather than as a dependent.
Syringe	A device used to inject fluid into or withdraw fluid from the body. Medical syringes consist of a needle attached to a hollow cylinder that is fitted with a sliding plunger. The downward movement of the plunger injects fluid; upward movement withdraws fluid.
Termination date	The day that health plan coverage ceases to be in effect.
Tumor	An abnormal benign or malignant new growth of tissue that possesses no physiological function and arises from uncontrolled usually rapid cellular proliferation.
Ultrasound	The diagnostic or therapeutic use of ultrasound and especially a noninvasive technique involving the formation of a two-dimensional image used for the examination and measurement of internal body structures and the detection of bodily abnormalities.
Urostomy	An ostomy for the elimination of urine from the body.
Uterine embryo lavage	A procedure by which the uterus is flushed to recover a pre-implantation embryo.
Zygote intra-fallopian transfer	An assisted reproductive procedure similar to *in vitro* fertilization and embryo transfer with the difference being that the fertilized embryo is transferred into the fallopian tube instead of the uterus.

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