Review of

CONNECTICUT MANDATED HEALTH INSURANCE BENEFITS

2014

UCONN HEALTH

CENTER FOR PUBLIC HEALTH
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Executive Summary

Pursuant to P.A. 09-179, the Insurance and Real Estate Committee of the Connecticut General Assembly (Committee) requested the Connecticut Insurance Department (CID) to review Connecticut's mandated health insurance benefits (mandates) vis-à-vis the federal Affordable Care Act (ACA) and other federal health insurance benefit laws and regulations. The Committee also requested the CID to update cost projections on all previously reviewed mandates and to report on any mandates that are no longer medically necessary. The CID contracted for the services of the University of Connecticut Center for Public Health and Health Policy (CPHHP) to perform this review, and contracted with OptumInsight, Inc. (Optum), to provide cost updates.

This report reviews all of Connecticut's mandated health insurance benefits, provides updated cost projections, and crosswalks the mandates to the Essential Health Benefits provisions of the federal Affordable Care Act and other federal laws that are applicable to health insurance benefits.

Section II provides background on the federal Affordable Care Act and its Essential Health Benefits (EHB) requirements, Connecticut's mandated health insurance benefits and the development of Connecticut's EHB benchmark plan.

Section III of this report discusses the cost updates, and Optum's report is included in Appendix III.

In Section IV, CPHHP identified 46 existing mandated benefits, of which 27 have been amended since they were most recently reviewed. Twelve of these were amended substantively and fifteen received technical amendments only. Three additional mandates were found that have never been reviewed by CPHHP.

Section V of the report lists the Connecticut mandates and identifies the Essential Health Benefit categories that are applicable to each. In many instances, more than one EHB category applies, since mandates often cover several types of service.

Twenty-two mandates have parallel federal laws on the same subject matter. These federal rules affect preventive health services, prescription drugs, mental health parity, routine patient care costs during clinical trials, direct access to obstetricians and gynecologists, mothers' and newborns' minimum post-delivery hospital stays, enrollment of newborns, and post-mastectomy reconstructive surgery. In addition, federal rules regarding age discrimination, annual and lifetime benefit limits and cost-sharing limits are applicable to Connecticut mandated benefits. The report analyzes these federal laws and compares them to the Connecticut mandate requirements.

CPHHP also reviewed the ACA and U.S. Department of Health and Human Services (HHS) rules on state-required benefits in excess of EHB, and determined that no current mandates are likely to be found in excess of EHB for the 2014 and 2015 plan years.

Finally, Section VI of the report reviews eight mandates for current medical necessity research. Mandates were chosen for medical necessity review if the prior review indicated a disagreement among the medical professions as to appropriate diagnosis or standards of care, or where supporting evidence for medical necessity was weak or mixed. Additionally, mandates that addressed preventive services or that were highly specific as to who would receive the benefit or how a service was to be provided were also reviewed, as standards of care tend to change over time.

CPHHP thanks the Connecticut Insurance Department for the opportunity to undertake this important research.

A report to the
Insurance and Real Estate Subcommittee
of the Connecticut General Assembly

REVIEW OF CONNECTICUT MANDATED HEALTH INSURANCE BENEFITS

2014

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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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I. Introduction

Public Act 09-179[1] established a process of review for existing and proposed health insurance benefit mandates (mandates), as defined in the legislation. It requires the Connecticut Insurance Department (CID) to evaluate Connecticut's health insurance benefit mandates as requested by the General Assembly's Committee on Insurance and Real Estate in July of each year. The Insurance Department is directed to contract for the services of the University of Connecticut Center for Public Health and Health Policy (CPHHP) to perform these reviews and evaluations. In prior years, CPHHP has evaluated a number of proposed mandates and already-enacted mandates which did not receive a review prior to their enactment.

In July 2014, the CID received a request from the Insurance Committee to report on the following items:

- Update the cost projections on all previously reviewed mandates to 2016 cost;
- Crosswalk all Connecticut mandates to the current Connecticut Benchmark Plan and the ACA Essential Health Benefit categories, including:
  - identify any changes to Connecticut's mandates since their initial reviews;
  - categorize each Connecticut mandate within an Essential Health Benefit (EHB) category,
  - crosswalk state mandates to federal mandates in the Affordable Care Act (ACA) and other federal laws; and
  - determine whether any mandates are likely to become the financial responsibility of the state under the ACA; and
- Determine whether any mandates should be repealed as no longer medically necessary or cost-effective.

A copy of the Committee's request is included in this report in Appendix I.

In accordance with Public Act 09-179, the CID has requested CPHHP to develop this report. The CID has contracted with OptumInsight, Inc. (Optum) to perform the actuarial evaluations and updated cost projections. A copy of Optum's report is included with this report as Appendix III.

[1] CGS § 38a-21.

II. Background

The Affordable Care Act

In 2010, Congress passed the Patient Protection and Affordable Care Act[2] and the Health Care and Education Reconciliation Act of 2010.[3] Together these laws are referred to as the Affordable Care Act (ACA).[4] This legislation, among other things, establishes a system of state and federal health insurance exchanges and sets minimum benefit and actuarial standards for health insurance policies sold on such exchanges. Some of the federal standards became effective immediately, such as the elimination of the pre-existing condition limitations and extension of coverage to children up to the age of 26. However, the majority of the benefit standards became effective for plan years beginning on or after January 1, 2014, when the state insurance exchanges became fully operational.

Section 1302 of the ACA requires all policies sold on the exchanges to provide insurance coverage for ten categories of "essential health benefits" (EHB). States are free to require policies issued through the exchange to cover benefits in addition to EHB, but the states are required to defray the cost of such additional state-required benefits either directly to the enrollee or to the plan issuer on behalf of the enrollee.[5]

This report will endeavor to crosswalk the requirements of the ACA and other federal health insurance benefit rules with Connecticut's mandated health insurance benefits and to address the other requests of the Insurance and Real Estate Committee.

Connecticut Health Benefit Mandates

Since the inception of Connecticut's Mandated Health Benefit Review Program in 2009, CPHHP has conducted 66 full reviews of existing and proposed mandated health benefits, or mandates. For the current report, Optum has provided updated cost estimates, and cost projections to 2016, of the 46 previously reviewed health benefit mandates that are currently law.

In Connecticut, the term "mandated health benefit" is defined by statute. It is "*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 [provider mandate]*;*

(B) offer or provide coverage for the screening, diagnosis or treatment of a particular disease or condition [condition mandate]*; 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 [treatment mandate]*."*[6]

A "mandated health benefit" also includes "*any proposed legislation to expand or repeal an existing statutory*

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2 Pub. L. 111-148.

3 Pub. L. 111-152.

4 Coverage of Certain Preventive Services under the Affordable Care Act, 78 Federal Register 39870 (July 2, 2013).

5 ACA Section 1311(d)(3)(B).

6 CGS § 38a-21.

obligation relating to health insurance coverage or medical benefits."[7]

Some mandates, then, such as the direct access to an obstetrician-gynecologist,[8] require coverage of specified providers; others, such as the autism spectrum disorder therapies mandate,[9] require coverage of certain conditions, while a third type of mandate requires coverage of particular services or devices, such as the ostomy-related supplies mandate.[10] Several mandates prohibit carriers from relying on specified reasons to deny coverage for otherwise covered services. The mobile field hospital mandate,[11] for example, prohibits carriers from denying coverage on the basis that the services were provided in the state's mobile field hospital; the clinical trials mandate[12] prohibits carriers from denying coverage on the basis that the care was provided as part of certain types of clinical trials.

There is no standard definition of what should be counted as a single mandate, what constitutes multiple mandates, or what should be considered components of one mandate. In Connecticut, individual and group policies are generally governed by separate statutory sections. Where there are parallel mandate provisions for individual and group policies, these provisions are counted as one mandate. Other than that, CPHHP has generally counted separate statutory sections as separate mandates for purposes of evaluation and review, regardless of the scope of the coverage required by the statutory section. (The clinical trials mandate serves as an exception to this general scheme of mandate counting: that mandate is described over several statutory sections.[13]) This method has the advantage of allowing easy reference between a CPHHP review and the relevant statutory provision. It also results, however, in wide variation in the scope of coverage that is counted as a single mandate.

Some mandates cover many types of providers, conditions or treatments, while others only cover one. For example, Connecticut's laws mandating the coverage of mental health or nervous conditions[14] require the coverage of nearly all of the conditions identified in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). The mandate requiring coverage of Lyme disease, on the other hand, focuses on only one specific condition.[15] Each of these statutory provisions, however, is counted as "one" mandate.

In some instances a particular type of insurance rule is counted as a separate health benefit mandate, whereas in other instances similar rules are merely components of another mandate. The statutory section requiring coverage of the services of physician assistants and certain nurses is counted as one mandate.[16] With mental health services, however, several provider rules are included as part of the mental health services mandate,[17] and so are not counted separately. The imaging services co-payment mandate limits carriers' discretion to impose cost-sharing for listed imaging services.[18] In other instances, cost-sharing rules are included as a component of a mandate, such as with the birth-to-three mandate,[19] and so are not counted separately. Thus, the scope of each mandate varies considerably.

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7 CGS § 38a-21.

8 CGS § 38a-503b; § 38a-530b.

9 CGS § 38a-488b; § 38a-514b.

10 CGS § 38a-492j; § 38a-518j.

11 CGS § 38a-498b; § 38a-525b.

12 CGS § 38a-504a *et seq.*; § 38a-542a *et seq.*

13 CGS § 38a-504a *et seq.*; § 38a-542a *et seq.*

14 CGS § 38a-488a; § 38a-514.

15 CGS § 38a-492h; § 38a-518h.

16 CGS § 38a-499; § 38a-526.

17 CGS § 38a-488a; § 38a-514.

18 CGS § 38a-511; § 38a-550.

19 CGS § 38a-490a; § 38a-516a.

The reviews fall into two broad categories: retrospective and prospective. For the retrospective reviews, evaluations of existing mandates are completed, using Connecticut-based data when available, for benefit claims that fall within the provisions of the mandate. For the prospective reviews, proposed mandates are evaluated before they are enacted into law. Several of the completed prospective reviews were of proposed amendments to existing mandates and, therefore, some current mandates have been both retrospectively and prospectively reviewed. The bulk of CPHHP retrospective reviews appear in the four volumes produced in 2010. The remaining reports, produced in 2009, 2011, 2012 and 2013, contain a few retrospective reviews and several prospective reviews of proposed benefit mandates. A few of these proposed mandates have since become state law, though most have not.

Essential Health Benefits

The ACA requires all policies sold on a state or federally facilitated health insurance exchange (Exchange) to include an essential health benefits (EHB) package. With a few exceptions, any fully-insured individual or small group policies sold after January 1, 2014, whether sold on or off the Exchange, must also cover the applicable EHB package.[20]

The EHB package consists of three basic components: coverage of EHB; cost-sharing requirements related to the coverage of individual benefits; and requirements regarding the actuarial value the carrier derives from the products it sells that comply with EHB requirements.[21,22]

The ACA does not itself define "essential health benefits" but, rather, delegates to the Secretary of Health and Human Services the responsibility of defining the term and identifying particular benefits as essential.[23] The ACA does require, however, that the benefits selected at least provide coverage for services that fall within ten statutorily identified health benefit categories.[24] These categories are:

- ambulatory patient services,
- emergency services,
- hospitalization,
- maternity and newborn care,
- mental health and substance use disorder services, including behavioral health treatment,
- prescription drugs,
- rehabilitative and habilitative services and devices,
- laboratory services,
- preventive and wellness services and chronic disease management, and
- pediatric services, including oral and vision care.[25,26]

Federal law includes a few provisions that restrict the Secretary's discretion in selecting benefits. Among these, the ACA directs that EHB must be equal in scope to benefits covered by a typical employer-

[20] 45 CFR 147.150 (a).

[21] 42 U.S.C. §18022 (a) provides: "[T]he term 'essential health benefits package' means . . . coverage that (1) provides for [EHB]; (2) limits cost-sharing for such coverage . . . and (3) . . . provides either the bronze, silver, gold, or platinum level of coverage."

[22] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12836 (February 25, 2013) (amending 45 CFR Parts 147, 155, and 156).

[23] 42 U.S.C. §18022 (b) (1).

[24] 42 U.S.C. §18022 (b) (1).

[25] 42 U.S.C. §18022 (b) (1).

[26] 45 CFR §156.110.

provided plan.[27] The ACA also requires the Secretary to ensure that EHB "(1) reflects appropriate balance among the 10 statutory EHB categories; (2) is not designed in such a way as to discriminate based on age, disability, or expected length of life; (3) takes into account the health care needs of diverse segments of the population; and (4) does not allow denial of EHB based on age, life expectancy, or disability."[28] The benefits selected also must comply with federal mental health parity rules, which generally require that coverage for mental health conditions be similar to coverage for physical conditions.[29,30,31] No enrollee may be excluded from an entire category of benefits, other than the category specific to pediatric services.[32,33]

The ACA delegates most of the task of determining which specific services are essential health benefits to the Secretary of Health and Human Services. The ACA itself specifies, however, that all small group and individual policies, with a few exceptions, cover certain recommended preventive health services.[34,35,36] The Secretary has interpreted this to mean recommended preventive health services are essential health benefits.[37,38]

The Secretary has not (as of October 1, 2014) promulgated a national set of EHB.[39] Instead, the Secretary adopted a transitional approach that allowed each state to participate in the selection of specific benefits that would constitute EHB for policies sold in that state[40] (although roughly half of the states chose not to do so).[41] These state-specific EHB packages will stay in effect for at least the 2014 and

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[27] 42 U.S.C. §18022 (b) (2) (A).

[28] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12835 (February 25, 2013) (amending 45 CFR Parts 147, 155, and 156).

[29] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12844 (February 25, 2013) (amending 45 CFR Parts 147, 155, and 156).

[30] 45 CFR §156.115 (a) (3).

[31] Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Program, 78 Fed. Reg. 68240 (November 13, 2013) (amending 45 CFR parts 146 and 147).

[32] CCIIO, Guide to Reviewing Essential Health Benefits Benchmark Plans, available at: http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html (accessed November 14, 2014).

[33] 45 CFR § 156.115 (a) (2).

[34] 45 CFR §156.115 (a) (4) (incorporating, by reference, 45 CFR §147.130).

[35] The Secretary has determined that these federally recommended preventive services are considered EHB. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 77 Fed. Reg. 70644, 70651 (November 26, 2012) (proposed amendment to 45 CFR Parts 147, 155, and 156).

[36] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12843 (February 25, 2013).

[37] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12843 (February 25, 2013).

[38] 45 CFR §156.115.

[39] Most of the regulations regarding the EHB package are found in 45 CFR Part 146 (requirements for the group health insurance market), Part 147 (health insurance reform requirements for the group and individual health insurance markets), Part 148 (requirements for the individual health insurance market), part 155 (exchange establishment standards and other related standards under the Affordable Care Act), and Part 156 (health insurance issuer standards under the Affordable Care Act, including standards related to Exchanges).

[40] The Secretary explained that "The [ACA] directed the Secretary to define EHB to include at least the 10 identified categories, while ensuring that the scope of EHB is equal to the scope of benefits provided under a typical employer plan. However, typical employer plans differ by state. The Secretary balanced these directives, and minimized market disruption, by directing plans to offer the 10 statutory EHB categories while allowing the state[s] to select the specific details of their EHB coverage by reference to one of a range of popularly selected plans offered in the state or as part of the FEHBP. Accordingly, the states continue to maintain their traditional role in defining the scope of insurance benefits and may exercise that authority by selecting a plan that reflects the benefit priorities of that state." Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12843 (February 25, 2013) (amending 45 CFR Parts 147, 155, and 156).

[41] Corlette S, Lucia K, Levin M. "Implementing the Affordable Care Act: Choosing an essential health benefits benchmark plan." Realizing Health Reform's Potential, The Commonwealth Fund (March 2013), available at: http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2013/Mar/1677_Corlette_implementing_ACA_choosing_essential_hlt_benefits_reform_brief.pdf (accessed January 6, 2015).

2015 plan years.[42] A rule recently proposed by U.S. Department of Health and Human Services (HHS) suggests that they will stay in effect through plan year 2016 as well.[43]

The Secretary identified several types of health insurance plans that might constitute a "typical employer provided plan."[44] States were directed to select one of the "typical" plans to serve as a "base-benchmark plan" for determining the particular benefits included as EHB in that state.[45, 46] States were not allowed to "mix and match" benefits from several base-benchmark options, but, rather, were required to choose a single plan to serve as the reference plan for the state's EHB.

If the selected base-benchmark plan lacked sufficient benefits in any of the statutory EHB categories, states were given specific procedures to choose benefits from other identified types of plans.[47] For most EHB categories, this consisted of choosing a category of benefits from one of the other base-benchmark plan options to supplement the selected base-benchmark plan.[48] If the state-selected base-benchmark plan lacked benefits for pediatric vision or dental benefits, states were directed to select either the Federal Employee Dental and Vision Insurance Plan (FEDVIP) with the largest national enrollment or the relevant Children's Health Insurance Program (CHIP) plan.[49]

HHS noted in the preamble to its 2013 Standards Related to Essential Health Benefits, Actuarial Value and Accreditation that many employer-sponsored plans do not identify habilitative services as a distinct category of covered services.[50] For plan years beginning in 2014 and 2015, it allowed alternative methods to meet the EHB requirement for Habilitative Services. These included having the state determine which habilitative services to include in the EHB plan;[51] if the state does not determine habilitative benefits, health insurance issuers may either provide habilitative services to the same extent that rehabilitative services are covered, or they may determine which habilitative services to cover and report this to HHS.[52] (Even in this last case, in which the carrier determines habilitative services, the provisions are still subject to the non-discrimination rules and other requirements of EHB.)

Regardless of the coverage in the EHB-benchmark plan, HHS also specified a few benefits that are prohibited from being considered EHB. These include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term and custodial nursing home care benefits and non-medically necessary orthodontia.[53]

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[42] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12841 (February 25, 2013) (amending 45 CFR Parts 147, 155, and 156).

[43] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 79 Fed. Reg. 70674 (November 26, 2014).

[44] 45 CRF §156.100. Specifically, states could select from "[1] The largest health plan by enrollment in any of the three largest small group insurance products by enrollment…[2] Any of the largest three employee health benefit plan options by enrollment offered and generally available to State employees in the State involved…[3] Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by aggregate enrollment that is offered to all health-benefits-eligible federal employees…[4] The coverage plan with the largest insured commercial non-Medicaid enrollment offered by a health maintenance organization operating in the State."

[45] Center for Consumer Information and Insurance Oversight. Essential Health Benefits Bulletin. U.S. Dept. ofHealth and Human Services (December 16, 2011) p. 8-9.

[46] 45 CFR §156.100.

[47] 45 CFR §156.110 (b).

[48] 45 CFR §156.110 (b) (1).

[49] 45 CFR §156.110 (b) (2) (pediatric oral services); 45 CFR §156.110 (b) (3) (pediatric vision services).

[50] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12843 (February 25, 2013).

[51] 45 CFR §156.110 (f).

[52] 45 CFR §156.115 (a) (5).

[53] 45 CFR §156.115 (d).

The final state EHB-benchmark plan, consisting of the base-benchmark plan and any necessary supplemental coverage, became that state's reference plan to determine which benefits are considered EHB in that state.[54,55] EHB serves as a federally required minimum of benefits that must be covered; states retain the ability to require that plans within their regulatory jurisdiction provide benefits in addition to EHB.[56]

Connecticut Benchmark Plan

In Connecticut, the Connecticut Health Insurance Exchange, otherwise known as Access Health CT, was created to establish the state's Exchange. It was tasked with, among other things, recommending an EHB-benchmark plan. A subcommittee of the Exchange, the Health Plan Benefits and Qualifications Advisory Committee (Advisory Committee) was formed in 2012 to study the federal base-benchmark plan options. The Advisory Committee recommended the ConnectiCare HMO plan as the base-benchmark plan, to be supplemented by the Oxford PPO plan for prescription drug coverage, CHIP-HUSKY B for pediatric dental care coverage, and the nation's largest FEDVIP for pediatric vision coverage.[57] The Advisory Committee also recommended that the carriers be allowed to define "habilitative services."[58] The recommendations were presented to the Health Insurance Exchange Board of Directors on July 26, 2012,[59] and the Board of Directors unanimously approved them.[60] Because Connecticut selected a base-benchmark plan that was subjected to state insurance regulation, the health benefits mandated by state law were covered by that plan and so became part the EHB requirements for policies sold on Connecticut's Exchange and elsewhere in the state.

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[54] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12840-12842 (February 25, 2013) (amending 45 CFR Parts 147, 155, and 156).

[55] Multi-state plans are subject to other standards established by the U.S. Office of Personnel Management. 45 CFR §156.105.

[56] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12837 (February 25, 2013) (amending 45 CFR Parts 147, 155, and 156).

[57] Report to the Board of Directors, Connecticut Health Insurance Exchange. Essential Health Benefits: Selecting and Supplementing a Benchmark Plan in Connecticut, Recommendation of the Health Plan Benefits and Qualification Advisory Committee (no date), available at: http://www.ct.gov/hix/lib/hix/Board_EHB_Report_-_Recommendation_FINAL.pdf (accessed November 17, 2014).

[58] Report to the Board of Directors, Connecticut Health Insurance Exchange. Essential Health Benefits: Selecting and Supplementing a Benchmark Plan in Connecticut, Recommendation of the Health Plan Benefits and Qualification Advisory Committee (no date), available at: http://www.ct.gov/hix/lib/hix/Board_EHB_Report_-_Recommendation_FINAL.pdf (accessed November 17, 2014), p. 23.

[59] Minutes, Connecticut Health Insurance Exchange Board of Directors Regular Meeting, Thursday, July 26, 2012, available at: http://www.ct.gov/hix/lib/hix/APPROVED__Minutes_72612_Health_Insurance_Exchange_Board_Meeting_.pdf (accessed November 17, 2014).

[60] Record of Votes, Connecticut Health Insurance Exchange Board of Directors Regular Meeting, Thursday, July 26, 2012, available at: http://www.ct.gov/hix/lib/hix/VotingJuly_26.pdf (accessed November 17, 2014).

III. 2016 Cost projections for previously reviewed mandates

The CID contracted with Optum to update cost projections on all state mandated health insurance benefits previously studied by CPHHP. Optum's report is attached to this report as Appendix III.

The mandate costs reported in the 2009-2013 reviews were based on prior years' claims data collected from the Connecticut-domiciled health insurers and managed care organizations. Each review also contained 5-year projections of such costs, based on assumptions by the actuaries of medical cost inflation (trend) and any changes in utilization of mandated services over that period of time. The present charge from the Insurance Committee is to update those 5-year projections to 2016 costs (the vast majority of the prior reviews projected costs to 2014). In order to perform this task, Optum developed cost data from its proprietary database of Connecticut group policies for claim years 2012 and 2013 and projected these costs to 2016. To provide a basis for comparison, Optum also took the original 5th year projections for each mandate and carried them forward to year 2016 using the same trend assumptions that were used in the original review.

The Optum report includes a number of mandates where the difference in projected costs was substantial. In some cases, prior reviews had addressed proposed mandates that were subsequently enacted with different language than the language that was reviewed. In other cases, mandates were amended to add additional coverage subsequent to CPHHP's review. In some cases, prescription drug costs for treating a mandated condition were not available from the carrier claims data when the initial review was performed. In this review, Optum was able to determine an estimated prescription drug cost from its claims database, thus increasing the estimated cost of the mandate. For some mandates, there are differences between group and individual policy coverage requirements. The texts of these mandates are listed in Appendix II, Table 3.

The Optum report contains more detailed explanations for those mandates with notable deviations from prior cost estimates and should be read together with this report.

It should also be noted that, like other mandated health benefit review programs,[61] Connecticut's program focuses primarily on providing estimates of the direct costs of the services covered by the mandates. The reviews do not provide an estimate for the cost of the law itself. This is an important distinction because, in many cases, the services required by the mandate likely would have been covered to some extent by the carriers regardless of state law. In such cases, the cost estimate may be greatly in excess of the actual incremental costs added by the mandate. In addition, while CPHHP reviews have noted instances where mandating coverage of a health benefit may provide indirect cost reductions or increases, these are typically speculative at the time of the CPHHP review (requiring assumptions about changes in human behavior resulting from insurance coverage) and, therefore, quantitative estimates are not usually provided.

Table III.1 gives the original 5th year projection for each mandate (column A), the original 5th year projection extended to 2016 (column B), and a new 2016 projection based on claims data for 2012 and 2013 from the Optum database (column C). It should be emphasized that all cost projections are estimates based on prior years' claims data and estimated medical cost trends. Actual costs may differ and costs of individual carriers may differ. The cost of each mandate has been estimated separately and should be considered separately. Because there may be some coverage overlap between the various mandates, it is not appropriate to merely sum up the costs of each individual mandate to generate a total cost of all mandates.

[61] Compass Health Analytics, Inc., "State-Mandated Health Insurance Benefits and Health Insurance Costs in Massachusetts," prepared for the Center for Health Information and Analysis, Commonwealth of Massachusetts. January, 2013.

Table III.1

2016 Cost Updates for Previously Reviewed Connecticut Health Benefit Mandates, by statute

Individual Policy Statute	Group Policy Statute	Original Enactment Year	Description	CPHHP Prior Review, Year,Vol./ Chapter	(A) Original 5th Year Projection	(B) Original Projection Trended to 2016	(C) New 2016 Estimated Cost
§ 38a-476b	§ 38a-476b	2001	Psychotropic drug availability	2010.III.1	$10.02	$11.57	$7.47
§ 38a-483c	§ 38a-513b	1999	Experimental treatments	2010.IV.1	$0.01	$0.00	$0.00
§ 38a-488a	§ 38a-514	1971	Mental or nervous conditions	2010.III.2	$10.33	$11.39	$31.82
§ 38a-488b	§ 38a-514b	2008	Autism spectrum disorder therapies	2010.II.6 2012.1	$0.04	$0.74	$0.69
§ 38a-490	§ 38a-516	1974	Coverage for newborns	2010.II.7	$6.03	$6.65	$7.06
§ 38a-490a	§ 38a-516a	1996	Birth-to-three	2010.I.8	$0.27	$0.29	$0.04
§ 38a-490b	§ 38a-516b	2001	Hearing aids for children twelve and under	2010.I.4	$0.01	$0.01	$0.00
§ 38a-490c	§ 38a-516c	2003	Craniofacial disorders	2010.I.5	$0.02	$0.03	$0.13
§ 38a-490d	§ 38a-535	1989	Blood lead screening and risk assessment	2010.II.8	$0.01	$0.01	$0.01
§ 38a-491a	§ 38a-517a	1999	Inpatient, outpatient, and one-day dental services	2010.I.6	$0.06	$0.07	$0.00
§ 38a-492	§ 38a-518	1975	Accidental ingestion of controlled drugs	2010.III.3	$0.04	$0.04	$0.03
§ 38a-492a	§ 38a-518a	1992	Hypodermic needles and syringes	2010.IV.4	$0.06	$0.07	$0.00
§ 38a-492b	§ 38a-518b	1994	Off-label use of certain drugs	2010.IV.2	$3.31	$3.83	$5.76
§ 38a-492c	§ 38a-518c	1997	Certain specialized foods	2010.II.9	$0.29	$0.32	$0.34
§ 38a-492d	§ 38a-518d	1997	Diabetes testing and treatment	2010.I.7	$5.59	$6.16	$10.25
§ 38a-492e	§ 38a-518e	1999	Diabetes self-management training	2010.I.1	$0.07	$0.08	$0.01
§ 38a-492f	§ 38a-518f	1999	Prescription drugs removed from formulary	2010.IV.5	$0.00	$0.03	$0.00
§ 38a-492g	§ 38a-518g	1999	Prostate cancer screening and treatment	2010.I.2 2012.4	$0.23	$0.25	$1.93
§ 38a-492h	§ 38a-518h	1999	Lyme disease treatments	2010.I.9	$0.34	$0.38	$0.34

Table III.1

2016 Cost Updates for Previously Reviewed Connecticut Health Benefit Mandates, by statute

Individual Policy Statute	Group Policy Statute	Original Enactment Year	Description	CPHHP Prior Review, Year,Vol./ Chapter	(A) Original 5th Year Projection	(B) Original Projection Trended to 2016	(C) New 2016 Estimated Cost
§ 38a-492i	§ 38a-518i	2000	Pain management	2010.IV.12	$0.00	$0.00	$0.00
§ 38a-492j	§ 38a-518j	2000	Ostomy-related supplies	2010.I.3	$0.07	$0.08	$0.10
§ 38a-492k	§ 38a-518k	2001	Colorectal cancer screening	2009.6 2010.I.10	$4.71	$4.56	$4.33
§ 38a-492l	§ 38a-516d	2006	Neuropsychological testing for children diagnosed with cancer	2010.II.10	$0.00	$0.00	$0.00
§ 38a-492o	§ 38a-518o	2011	Bone marrow testing	2009.5	$0.00	$0.01	$0.01
§ 38a-493	§ 38a-520	1975	Home health care	2010.IV.6	$1.70	$1.97	$0.19
§ 38a-496	§ 38a-524	1982	Occupational therapy	2010.III.6	$1.05	$1.15	$0.21
§ 38a-498	§ 38a-525	1983	Ambulance services	2010.IV.7	$2.76	$3.04	$2.10
§ 38a-498b	§ 38a-525b	2005	Mobile field hospital	2010.IV.11	$0.00	$0.00	$0.00
§ 38a-498c	§ 38a-525c	2006	Elevated blood alcohol content	2010.III.4	$0.04	$0.04	$0.28
§ 38a-499	§ 38a-526	1984	Services of physician assistants and certain nurses	2010.III.7	$0.00	$0.00	$0.00
§ 38a-502	§ 38a-529	1988	Services provided by the Veterans' Home	2010.III.8	$0.40	$0.44	$0.00
§ 38a-503	§ 38a-530	1988	Breast cancer screening	2010.II.1 2011.2	$3.24	$4.58	$2.70
§ 38a-503b	§ 38a-530b	1995	Direct access to obstetrician-gynecologists	2010.III.9	$0.00	$0.00	$0.00
§ 38a-503c	§ 38a-530c	1996	Maternity minimum stay	2010.II.2	$2.25	$2.48	$1.00
§ 38a-503d	§ 38a-530d	1997	Mastectomy or lymph node dissection minimum stay	2010.II.3	$0.12	$0.13	$0.01
§ 38a-503e	§ 38a-530e	1999	Prescription contraceptives	2010.II.4	$1.46	$1.61	$1.92
§ 38a-504	§ 38a-542	1979	Tumors and leukemia	2010.I.11	$13.37	$14.74	$36.72

Table III.1

2016 Cost Updates for Previously Reviewed Connecticut Health Benefit Mandates, by statute

Individual Policy Statute	Group Policy Statute	Original Enactment Year	Description	CPHHP Prior Review, Year,Vol./ Chapter	(A) Original 5th Year Projection	(B) Original Projection Trended to 2016	(C) New 2016 Estimated Cost
§ 38a-504a-g	§ 38a-542a-g	2001	Clinical trials	2010.IV.3	$0.00	$0.00	$0.00
§ 38a-507	§ 38a-534	1989	Chiropractic services	2010.III.10	$3.08	$3.39	$1.71
§ 38a-509	§ 38a-536	1989	Infertility diagnosis and treatment	2010.II.5	$2.40	$3.75	$1.06
§ 38a-510	§ 38a-544	1989	Mail order pharmacies and step therapy	2010.IV.8	$0.00	$0.00	$0.00
§ 38a-511	§ 38a-550	2006	Co-payments regarding in-network imaging services	2010.IV.9	$1.22	$1.34	$1.36
(group only)	§ 38a-523	1982	Rehabilitative services (mandatory offer)	2010.IV.10	$2.94	$3.24	$0.82
(group only)	§ 38a-533	1974	Medical complications of alcoholism	2010.III.5	$0.45	$0.50	$15.85
(group only)	§ 38a-535	1989	Preventive pediatric care	2010.II.11	$2.40	$2.65	$3.05
(group only)	§ 38a-547	1990	Maternity benefits and pregnancy care following policy termination	2010.IV.13	$0.00	$0.00	$0.00

IV. Post-review amendments and unreviewed mandated benefits

Of the 46 previously reviewed health benefit mandates that are currently law, 27 have been amended in some manner since the most recent review. Most of these amendments, however, are technical or minor or do not otherwise directly affect the mandated coverage of the service. A full list of all of the mandates that have been amended since the most recent review, along with the amended text, appears in Appendix II.

Twelve of the mandates have been amended in a manner that might affect coverage of the service itself. The substance of these are summarized in table IV.1. In cases where a mandate was reviewed retrospectively, an amendment proposed and reviewed, and the amendment subsequently enacted, the amendments listed are those that came after the most recently reviewed amendment.

Three of these, the mandates for mental or nervous conditions, autism spectrum disorder therapies, and birth-to-three coverage, were amended to account for changes in the way that autism spectrum disorder is described in the most recent edition of the DSM, which was released in 2013. Benefit levels were increased for birth-to-three and ostomy-related supplies. Physiatrists were added as types of providers covered under the pain management mandate. Newborn coverage was increased from 31 to 61 days. Four mandates related to the coverage of prescription drugs were amended. The types of conditions covered by the off-label use of drugs were extended to include "disabling or life-threatening chronic disease." Carriers now may not require the use of step therapy for more than 60 days, and are prohibited from requiring use of over-the-counter drugs before covering brand name drugs prescribed by a pain management specialist. Oral anti-cancer drugs must be provided in parity with intravenous anti-cancer drugs. The types of trials included in the clinical trials mandate was expanded, and the statutorily identified source for treatment guidelines for colorectal and breast cancer screenings were altered.

Table IV.1 *Summary of substantive amendments to mandates after the most recent review*

State provision	Public Act	Summary of amendments directly affecting benefits
Mental or nervous conditions		
CGS § 38a-488a; § 38a-514	13-84, s. 3, 4	An insured diagnosed with autism spectrum disorder before the release of the DSM 5 shall be covered pursuant to §§ 38a-488b, 38a-514b.
Autism spectrum disorder therapies		
CGS § 38a-488b; § 38a-514b	13-84, s. 1, 2	Any insured diagnosed with autism spectrum disorder prior to the release of DSM 5 shall be covered at least at the same benefit levels covered specified before the release of DSM 5.
Coverage for newborns		
CGS § 38a-490; § 38a-516	11-171, s. 3, 4	Increases coverage period for newborns from 31 to 61 days.
Birth-to-three		
CGS § 38a-490a; § 38a-516a	Sept. Sp. Sess. 09-3, s. 45, 46	Increases maximum benefit to $6,400 per child per year and $19,200 per child for the total three year period.
	11-44, s. 147, 148	No policy, other than a high deductible plan, may impose co-insurance, co-payment, deductible or other out-of-pocket expenses.
		(Group polices, only) The birth-to-three coverage mandate does not increase the autism diagnosis and treatment coverage mandated by CGS § 38a-514b.
	12-44, s. 1, 2	Prohibits carriers from certain actions that are adverse to the insured that are the result of the insured claiming birth-to-three related coverage.
	13-84, s. 5, 6	Coverage for children diagnosed with autism spectrum disorder before the release of the DSM 5 must be provided at least at the same levels before the release of the DSM 5.
Off-label use of certain drugs		
CGS § 38a-492b; § 38a-518b	11-172, s. 15, 16	Extends mandate to include drugs that treat "disabling or life-threatening chronic diseases."
Pain management		
CGS § 38a-492i; § 38a-518i	11-169, s. 1, 2	Prohibits carriers from requiring use of over-the-counter drugs or other brand name drugs before covering prescribed drugs.
	12-197, s. 20, 21	Adds "physiatrist" to list of "pain management specialist."
Ostomy-related supplies		
CGS § 38a-492j; § 38a-518j	11-204, s. 1, 2	Increases annual coverage to $2,500.

Table IV.1 *Summary of substantive amendments to mandates after the most recent review*

State provision	Public Act	Summary of amendments directly affecting benefits
Colorectal cancer screening		
CGS § 38a-492k; § 38a-518k	11-83, s. 1, 2	Adds the American College of Radiology as a source of guidance for the screening. Prohibits cost-share for subsequent colonoscopies, except in high deductible plans.
	12-61, s. 1, 2	Eliminates American College of Gastroenterology and the American College of Radiology from sources of screening guidance.
	12-190, s. 1, 2	Prohibits deductibles for screening colonoscopy or a screening sigmoidoscopy.
Breast cancer screening		
CGS § 38a-503; CGS § 38a-530	12-150, s. 1, 2	Removes American College of Radiology from list of guideline sources for MRI screening coverage.
	14-97, s. 1, 2	Limits co-payments for ultrasound to $20.
Tumors and leukemia		
CGS § 38a-504; § 38a-542	10-63, s. 1, 2	Coverage for orally administered anti-cancer drugs must be no less favorable than coverage for intravenously administered cancer drugs.
Clinical trials		
CGS § 38a-504a; § 38a-542a	11-172, s. 1, 8	Expands covered trials to include trials to treat "disabling or life-threatening chronic diseases in human beings."
§ 38a-504b; § 38a-542b	11-172, s. 2, 9	Adds required coverage for trials that are "qualified to receive Medicare coverage of its routine costs under the Medicare Clinical Trial Policy…"
Mail-order pharmacies and step therapy		
CGS § 38a-510; § 38a-544	14-118, s. 1, 2	Defines step therapy and prohibits carriers from requiring step therapy beyond 60 days. Requires procedures for providers to request discontinuation of step therapy before expiration of 60 days.

CPHHP identified three statutory sections that contain provisions that are likely to satisfy the state definition of health benefit mandate, but for which CPHHP has not conducted a full review (Table IV.2).[62] The three identified provisions all apply to both individual and group policies. One appears to be a provider-type mandate, requiring the coverage of otherwise covered services when performed by dentists; another mandates the coverage of care for a specified condition, coverage for wound care for the treatment of epidermolysis bullosa; and the third is a cost-sharing mandate for physical therapy and occupational therapy that went into effect on January 1, 2015.

[62] By agreement with the CID, any new full statutory reviews will be conducted as a separate report after the conclusion of the present report.

Table IV.2 *Unreviewed state statutes*

Benefit	Individual	Group	Enactment date
Services performed by a dentist	§ 38a-491	§ 38a-517	1975
Wound care for epidermolysis bullosa	§ 38a-492n	§ 38a-518m	2010
Co-payments for physical therapy and occupational therapy	§ 38a-511a	§ 38a-550a	2015

V. Mandates crosswalk to essential health benefits and other federal provisions

Federal EHB and other federal laws

CPHHP created a crosswalk between Connecticut's health benefit mandates and federal health benefit requirements that apply to individual and group policies pursuant to the ACA and other federal law. Specifically, we have categorized Connecticut's mandates within the federal EHB categories; compared federal benefit requirements (other than those arising solely from the EHB-benchmark) that are parallel to Connecticut mandates to determine whether federal and state rules require similar or different coverage; and investigated whether any mandates enacted or amended after December 31, 2011 will likely lead to state cost-defray liability for policies sold on the Exchange.

A. Federal EHB categories and Connecticut mandated health benefits

CPHHP created a crosswalk between Connecticut's health benefit mandates and federal EHB categories. An operating definition for each of the 10 EHB categories is provided along with a table of relevant state mandates. For most categories, a mandate was listed in an EHB category if any of the services falling within the ambit of the mandate also fell within the category. Because most mandates cover several types of care, this has resulted in many mandates being listed under multiple EHB categories. Connecticut's mandates governing prescription drugs, however, were not sorted in this manner. Rather, mandates that are primarily directed at prescription drug coverage, such as the mail order pharmacies mandate, were sorted exclusively in the prescription drug EHB category, even when those mandates might affect somewhat the mandates that are sorted into other EHB categories.

The Advisory Committee for the Exchange considered a crosswalk of Connecticut state mandates and the EHB categories that was presented to it during the summer of 2012.[63] The Advisory Committee crosswalk did not include the definitions of the EHB categories it relied upon to sort the mandates. In addition, several of Connecticut's health benefit mandates did not appear on the Advisory Committee crosswalk, while several other state insurance laws that do not meet the state definition of health benefit mandate did. Still, we considered closely the Advisory Committee crosswalk while creating the one presented here. In many instances, the mandates are sorted similarly.

The state definition of health benefit mandate is broader than the definition of the similar federal term "state-required benefit." This is discussed more fully in section V.C. Where a state mandate does not appear to meet the federal definition of state-required benefit as identified by the Center for Consumer

[63] Classification of State Mandated Benefits Under the ACA's Ten Categories of Care (no date), available at: http://www.ct.gov/hix/lib/hix/Exhibit_1._Classification_of_State_Mandated_Benefits.pdf (accessed November 17, 2014).

Information and Insurance Oversight (CCIIO) of the Centers for Medicare and Medicaid Services,[64] this is indicated with italicized font in the EHB crosswalk tables.

A brief definition, or potential definition, is provided for each of the EHB categories. These definitions do not have their source in the federal EHB package rules. HHS has explicitly declined requests to particularly define the EHB category labels.[65] Rather, the definitions here are from other federal sources where available, particularly the glossary provided by HHS on the federal Exchange website. Where federal definitions are unavailable or incomplete, a definition from Connecticut's base-benchmark plan, ConnectiCare's HMO policy, is used. In some instances, examples of particular benefits covered by the base-benchmark plan are listed.

Table 5 in Appendix II indicates all of the potentially relevant EHBs for each mandate.

(1) Ambulatory Patient Services

Outpatient services include treatment of an illness or injury that occurs in a doctor's office or in the home. ConnectiCare's HMO policy lists primary care provider office services, specialist office services, gynecological office services, maternity care office services, allergy testing, laboratory services, radiological services, outpatient rehabilitative therapy, and chiropractic services as falling under "Outpatient Services."[66]

Table V.1 *Ambulatory Patient Services*

State health benefit mandate	Individual	Group
Experimental treatments	§ 38a-483c	§ 38a-513b
Mental or nervous conditions	§ 38a-488a	§ 38a-514
Autism spectrum disorder therapies	§ 38a-488b	§ 38a-514b
Coverage for newborns	*§ 38a-490*	*§ 38a-516*
Craniofacial disorders	§ 38a-490c	§ 38a-516c
Blood lead screening and risk assessment	§ 38a-490d	§ 38a-535
Services performed by dentists	*§ 38a-491*	*§ 38a-517*
Inpatient, outpatient, and one-day dental services	§ 38a-491a	§ 38a-517a
Diabetes testing and treatment	§ 38a-492d	§ 38a-518d
Prostate cancer screening and treatment	§ 38a-492g	§ 38a-518g
Lyme disease treatments	§ 38a-492h	§ 38a-518h
Pain management	§ 38a-492i	§ 38a-518i
Colorectal cancer screening	§ 38a-492k	§ 38a-518k
Neuropsychological testing for children diagnosed with cancer	§ 38a-492l	§ 38a-516d
Wound care for epidermolysis bullosa	§ 38a-492n	§ 38a-518m
Occupational therapy	§ 38a-496	§ 38a-524
Services of physician assistants and certain nurses	*§ 38a-499*	*§ 38a-526*
Breast cancer screening	§ 38a-503	§ 38a-530
Direct access to obstetrician-gynecologists	*§ 38a-503b*	*§ 38a-530b*

Italicized font indicates Connecticut health benefit mandates that do not appear on CCIIO's state-required benefit list.

[64] Center for Consumer Information and Insurance Oversight. Connecticut – required benefits, Available at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/ct-state-required-benefits.pdf (Accessed on Jan 14, 2015).

[65] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12843 (February 25, 2013).

[66] ConnectiCare HMO, p. 27-28.

Table V.1 *Ambulatory Patient Services*

State health benefit mandate	Individual	Group
Tumors and leukemia	§ 38a-504	§ 38a-542
Clinical trials	§ 38a-504a *et seq.*	§ 38a-542a *et seq.*
Chiropractic services	*§ 38a-507*	*§ 38a-534*
Infertility diagnosis and treatment	§ 38a-509	§ 38a-536
Co-payments for occupational therapy and physical therapy	*§ 38a-511a*	*§ 38a-550a*
Rehabilitative services (mandatory offer)	*(group only)*	*§ 38a-523*
Medical complications of alcoholism	(group only)	§ 38a-533
Preventive pediatric care	(group only)	§ 38a-535
Maternity benefits and pregnancy care following policy termination	*(group only)*	*§ 38a-547*

Italicized font indicates Connecticut health benefit mandates that do not appear on CCIIO's state-required benefit list.

(2) Emergency Services

An emergency is a "sudden and unexpected onset of an illness or injury with severe symptoms whereby a prudent layperson, acting reasonably, would believe that emergency medical treatment is needed."[67] For mental health care, an emergency exists when a person is "at risk of suffering serious physical impairment or death, or of becoming a threat to himself/herself or others, or of significantly decreasing his/her functional capability if treatment is withheld for greater than 24 hours."[68] Emergency care can be provided in a walk-in urgent care center, emergency room, or during the provision of medical transport services. Emergency services do not include routine physical exams and immunizations.[69]

Table V.2 *Emergency Services*

State health benefit mandate	Individual	Group
Mental or nervous conditions	§ 38a-488a	§ 38a-514
Coverage for newborns	*§ 38a-490*	*§ 38a-516*
Inpatient, outpatient, and one-day dental services	§ 38a-491a	§ 38a-517a
Accidental ingestion of a controlled drug	§ 38a-492	§ 38a-518
Ambulance services	§ 38a-498	§ 38a-525
Mobile field hospital	*§ 38a-498b*	*§ 38a-525b*
Elevated blood alcohol content	*§ 38a-498c*	*§ 38a-525c*
Services of physician assistants and certain nurses	*§ 38a-499*	*§ 38a-526*
Treatment of medical complications of alcoholism	(group only)	§ 38a-533
Maternity benefits and pregnancy care following policy termination	*(group only)*	*§ 38a-547*

Italicized font indicates Connecticut health benefit mandates that do not appear on CCIIO's state-required benefit list.

[67] ConnectiCare HMO, p. 29 (internal quotations omitted).
[68] ConnectiCare HMO, p. 29.
[69] ConnectiCare HMO, p. 29.

(3) Hospitalization

Hospital services are those services customarily provided in an acute care general hospital.[70] The ConnectiCare HMO reference policy specifically notes that these services include blood transfusions, drugs and biologicals, intensive care and related services, laboratory services, nursing care, operating room and related facilities, physician services in the hospital when not billed by physicians, room and board, several types of therapy, dental anesthesia, mastectomy services, maternity services, solid organ transplants and bone marrow transplants, transportation, ambulatory services, radiological diagnostic procedures, podiatric procedures, skilled nursing and rehabilitation facilities, medically necessary skilled nursing provided in a skilled nursing facility, and acute rehabilitation in certain settings.[71]

Table V.3 *Hospitalization*

State health benefit mandates	Individual	Group
Experimental treatments	§ 38a-483c	§ 38a-513b
Mental or nervous conditions	§ 38a-488a	§ 38a-514
Coverage for newborns	*§ 38a-490*	*§ 38a-516*
Craniofacial disorders	§ 38a-490c	§ 38a-516c
Inpatient, outpatient, and one-day dental services	§ 38a-491a	§ 38a-517a
Accidental ingestion of a controlled drug	§ 38a-492	§ 38a-518
Prostate cancer screening and treatment	§ 38a-492g	§ 38a-518g
Bone marrow testing	§ 38a-492o	§ 38a-518o
Ambulance services	§ 38a-498	§ 38a-525
Mobile field hospital	*§ 38a-498b*	*§ 38a-525b*
Services of physician assistants and certain nurses	*§ 38a-499*	*§ 38a-526*
Services provided by the Veterans' Home	*§ 38a-502*	*§ 38a-529*
Maternity minimum stay	§ 38a-503c	§ 38a-530c
Mastectomy or lymph node dissection minimum stay	§ 38a-503d	§ 38a-530d
Tumors and leukemia	§ 38a-504	§ 38a-542
Clinical trials	§ 38a-504a *et seq.*	§ 38a-542a *et seq.*
Infertility diagnosis and treatment	§ 38a-509	§ 38a-536

Italicized font indicates Connecticut health benefit mandates that do not appear on CCIIO's state-required benefit list.

(4) Maternity and Newborn Care

The ConnectiCare HMO does not define either maternity or newborn care. Newborn care is listed under "Other preventive services"[72] and maternity care appears under "Outpatient Services"[73] and "Hospital Services."[74] In its 2011 report to HHS, the Department of Labor defined "maternity care" as medical coverage throughout the woman's pregnancy, including diagnostic testing.[75]

[70] ConnectiCare HMO, p. 29.

[71] ConnectiCare HMO, p. 29-30.

[72] ConnectiCare HMO, p. 27.

[73] ConnectiCare HMO, p. 27.

[74] ConnectiCare HMO, p. 30.

[75] U.S. Department of Labor, Selected medical benefits; a report from the Department of Labor to the Department of Health and Human Services. April 15, 2011. Available at http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf. Accessed on January 21, 2015.

Table V.4 *Maternity and Newborn Care*

State health benefit mandate	Individual	Group
Coverage for newborns	*§ 38a-490*	*§ 38a-516*
Birth-to-three	§ 38a-490a	§ 38a-516a
Craniofacial disorders	§ 38a-490c	§ 38a-516c
Certain specialized foods	§ 38a-492c	§ 38a-518c
Services of physician assistants and certain nurses	*§ 38a-499*	*§ 38a-526*
Direct access to obstetrician-gynecologist	*§ 38a-503b*	*§ 38a-530b*
Maternity minimum stay	§ 38a-503c	§ 38a-530c
Preventive pediatric care	(group only)	§ 38a-535
Maternity benefits and pregnancy care following policy termination	*(group only)*	*§ 38a-547*

Italicized font indicates Connecticut health benefit mandates that do not appear on CCIIO's state-required benefit list.

(5) Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment
The ConnectiCare HMO reference policy defines "inpatient mental health services," "inpatient alcohol and substance abuse services," and "outpatient mental health and alcohol substance abuse treatment":

> **Inpatient mental health services:** "*Medically necessary inpatient mental health services, as defined in the most recent edition of the American Psychiatric Association's 'Diagnostic and Statistical Manual of Mental Disorders,' rendered in an acute care general Hospital or a residential treatment facility;*"
>
> **Inpatient Alcohol and Substance Abuse Service:** "*Medically necessary inpatient services, supplies and medications in connection with medical complications of alcoholism, such as cirrhosis of the liver, gastrointestinal bleeding, pneumonia and delirium tremens, as defined in the most recent edition of the American Psychiatric Association's 'Diagnostic and Statistical Manual of Mental Disorders*"
>
> **Outpatient Mental Health and Alcohol and Substance Abuse Treatment:** "*Medically necessary outpatient services for the diagnosis and treatment of mental illnesses, as defined in the most recent edition of the American Psychiatric Association's 'Diagnostic and Statistical Manual of Mental Disorders'…*" Excluded from the definition are: "*caffeine-related disorders, communication disorders, learning disorders, mental retardation, motor skills disorders, relational disorders, sexual deviation, and other conditions that may be a focus of clinical attention not defined as mental disorders in the most recent edition of the American Psychiatric Association's 'Diagnostic and Statistical Manual of Mental Disorders.'*"[76]

[76] ConnectiCare HMO, p. 32.

Table V.5 *Mental Health and Substance Use Disorder Services*

State health benefit mandate	Individual	Group
Mental or nervous conditions	§ 38a-488a	§ 38a-514
Autism spectrum disorder therapies	§ 38a-488b	§ 38a-514b
Birth-to-three	§ 38a-490a	§ 38a-516a
Neuropsychological testing for children diagnosed with cancer	§ 38a-492l	§ 38a-516d
Services of physician assistants and certain nurses	*§ 38a-499*	*§ 38a-526*
Services provided by the Veterans' Home	*§ 38a-502*	*§ 38a-529*
Rehabilitative services (mandatory offer)	*(group only)*	*§ 38a-523*
Preventive pediatric care	(group only)	§ 38a-535

Italicized font indicates Connecticut health benefit mandates that do not appear on CCIIO's state-required benefit list.

(6) Prescription Drugs

For purposes of EHB, prescription drugs are drugs that are listed in the United States Pharmacopeia (USP), other than drugs for abortion services.[77] To comply with EHB, a policy must cover at least one drug in each category and class of the USP or the same number of prescription drugs in each category and class as covered in the EHB-benchmark plan (whichever provides greater coverage).[78] HHS has proposed a less rigid approach to satisfying the prescription drug coverage requirement for plan years starting in 2016.[79]

Table V.6 *Prescription Drugs*

State health benefit mandate	Individual	Group
Psychotropic drug availability	§ 38a-476b	§ 38a-476b
Experimental treatments	§ 38a-483c	§ 38a-513b
Mental or nervous conditions	§ 38a-488a	§ 38a-514
Autism spectrum disorder therapies	§ 38a-488b	§ 38a-514b
Coverage for newborns	*§ 38a-490*	*§ 38a-516*
Hypodermic needles and syringes	§ 38a-492a	§ 38a-518a
Off-label use of certain drugs	§ 38a-492b	§ 38a-518b
Certain specialized foods	§ 38a-492c	§ 38a-518c
Diabetes testing and treatment	§ 38a-492d	§ 38a-518d
Prescription drugs removed from formulary	*§ 38a-492f*	*§ 38a-518f*
Prostate cancer screening and treatment	§ 38a-492g	§ 38a-518g
Lyme disease treatments	§ 38a-492h	§ 38a-518h
Pain management	§ 38a-492i	§ 38a-518i
Prescription contraceptives	§ 38a-503e	§ 38a-530e

Italicized font indicates Connecticut health benefit mandates that do not appear on CCIIO's state-required benefit list.

[77] 45 CFR §156.122.

[78] 45 CFR §156.122.

[79] Patient Protection Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 79 Fed. Reg. 70675, 70718-70722 (November 26, 2014).

Table V.6 *Prescription Drugs*

State health benefit mandate	Individual	Group
Tumors and leukemia	§ 38a-504	§ 38a-542
Clinical trials	§ 38a-504a *et seq.*	§ 38a-542a *et seq.*
Infertility diagnosis and treatment	§ 38a-509	§ 38a-536
Mail order pharmacies and step therapy	§ 38a-510	§ 38a-544
Rehabilitative services (mandatory offer)	*(group only)*	*§ 38a-523*
Medical complications of alcoholism	(group only)	§ 38a-533

Italicized font indicates Connecticut health benefit mandates that do not appear on CCIIO's state-required benefit list.

(7) Rehabilitative and Habilitative Services and Devices

The glossary of terms on the federal Health Insurance Exchange's website defines rehabilitative services as: "Health care services that help [a person] keep, get back or improve skills and functioning for daily living that have been lost or impaired because [a person] was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings."[80]

The federal glossary defines habilitative services as "health care services that help [a person] keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings."[81]

The Connecticut base-benchmark plan covers medically necessary "short-term outpatient rehabilitative therapy if they are expected to return function to pre-illness or pre-injury levels."[82] These services include physical therapy, occupational therapy and speech therapy, but only to restore function which has been lost due to injury or illness. Therapies for developmental delays that are not a result of injury or illness are not covered; the only exception to this rule is for autism services or Birth-to-Three services which are required by state law.[83]

Even though some habilitative services are covered in the base-benchmark plan, HHS does not consider Connecticut's EHB plan to meet the Habilitative Services requirement of EHB.[84]

In recent guidance published in the Federal Register in November 2014, HHS has proposed for plan years beginning in 2016 to adopt a uniform definition of habilitative services and to remove the option for plan issuers to determine the scope of habilitative services to be covered.[85] The definition it has proposed is the one given above from the federal glossary.

Connecticut mandated health insurance benefits that fall under this EHB category include the following:

[80] "Rehabilitative/Rehabilitation Services," in Healthcare.gov Glossary, available at: https://www.healthcare.gov/glossary/rehabilitative-rehabilitation-services/ (accessed December 29, 2014).

[81] "Habilitative/Habilitation Services," in Healthcare.gov Glossary, available at: https://www.healthcare.gov/glossary/habilitative-habilitation-services/ (accessed December 29, 2014).

[82] ConnectiCare HMO, p. 28.

[83] ConnectiCare HMO, p. 28.

[84] Appendix A: List of Essential Health Benefits Benchmarks at 78 Fed. Reg. no. 37, page 12869-72

[85] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 (February 25, 2013), 79 Fed. Reg. 70674, 70717 (November 26, 2014).

Table V.7 *Rehabilitative and Habilitative Services and Devices*

State health benefit mandate	Individual	Group
Autism spectrum disorder therapies	§ 38a-488b	§ 38a-514b
Birth-to-three	§ 38a-490a	§ 38a-516a
Hearing aids for children twelve and under	§ 38a-490b	§ 38a-516b
Ostomy-related supplies	§ 38a-492j	§ 38a-518j
Home health care	§ 38a-493	§ 38a-520
Occupational therapy	§ 38a-496	§ 38a-524
Services provided by the Veterans' Home	*§ 38a-502*	*§ 38a-529*
Chiropractic services	*§ 38a-507*	*§ 38a-534*
Co-payments for physical therapy and occupational therapy	*§ 38a-511a*	*§ 38a-550a*
Rehabilitative services (mandatory offer)	*(group only)*	*§ 38a-523*

Italicized font indicates Connecticut health benefit mandates that do not appear on CCIIO's state-required benefit list.

(8) Laboratory Services

Neither the federal exchange's glossary nor the ConnectiCare HMO policy defines "laboratory services."[86] The ConnectiCare HMO policy does, however, cover "outpatient laboratory services" generally. It also mentions that laboratory services are covered in its description of other benefits, such as emergency care.[87]

Table V.8 *Laboratory Services*

State health benefit mandate	Individual	Group
Experimental treatments	§ 38a-483c	§ 38a-513b
Coverage for newborns	*§ 38a-490*	*§ 38a-516*
Blood lead screening and risk assessment	§ 38a-490d	§ 38a-535
Diabetes testing and treatment	§ 38a-492d	§ 38a-518d
Prostate cancer screening and treatment	§ 38a-492g	§ 38a-518g
Lyme disease treatments	§ 38a-492h	§ 38a-518h
Colorectal cancer screening	§ 38a-492k	§ 38a-518k
Bone marrow testing	§ 38a-492o	§ 38a-518o
Breast cancer screening	§ 38a-503	§ 38a-530
Tumors and leukemia	§ 38a-504	§ 38a-542
Clinical trials	§ 38a-504a *et seq.*	§ 38a-542a *et seq.*
Infertility diagnosis and treatment	§ 38a-509	§ 38a-536
Co-payments regarding in-network imaging services	*§ 38a-511*	*§ 38a-550*

Italicized font indicates Connecticut health benefit mandates that do not appear on CCIIO's state-required benefit list.

(9) Preventive and Wellness Services and Chronic Disease Management

The glossary provided on the federal Exchange's website includes entries for "preventive health services," "wellness programs," and "chronic disease management."

[86] ConnectiCare HMO, p. 27.

[87] ConnectiCare HMO, p. 29-30.

Preventive health services are "[r]outine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems."[88] Federal law mandates dozens of specific preventive services, as discussed in section V.B.

Wellness programs are programs that are "intended to improve and promote health and fitness." Some examples are smoking cessation classes, diabetes management programs and weight loss programs.[89]

Chronic disease management is an "integrated care approach" that may include screenings, check-ups, treatment monitoring, and patient education.[90]

Table V.9 *Preventive and Wellness Services and Chronic Disease Management*

State health benefit mandate	Individual	Group
Coverage for newborns	*§ 38a-490*	*§ 38a-516*
Early intervention services (Birth-to-three Program)	§ 38a-490a	§ 38a-516a
Blood lead screening and risk assessment	§ 38a-490d	§ 38a-535
Breast cancer screening	§ 38a-503	§ 38a-530
Certain specialized foods	§ 38a-492c	§ 38a-518c
Diabetes testing and treatment	§ 38a-492d	§ 38a-518d
Diabetes self-management	§ 38a-492e	§ 38a-518e
Pain management	§ 38a-492i	§ 38a-518i
Colorectal cancer screening	§ 38a-492k	§ 38a-518k
Wound care for epidermolysis bullosa	§ 38a-492n	§ 38a-518m
Home health care	§ 38a-493	§ 38a-520
Services provided by the Veterans' Home	*§ 38a-502*	*§ 38a-529*
Tumors and leukemia	§ 38a-504	§ 38a-542
Treatment of medical complications of alcoholism	(group only)	§ 38a-533
Preventive pediatric care	(group only)	§ 38a-535

Italicized font indicates Connecticut health benefit mandates that do not appear on CCIIO's state-required benefit list.

(10) Pediatric Services, including Oral and Vision Care

Pediatric care includes routine examinations and preventive care.[91] HHS has stated that, for purposes of this EHB category, "pediatric services" are services provided to an individual under the age of 19 years, though states may set a higher age limit.[92] (The Bright Futures Guidelines, which HHS has adopted as one of the sources of federally "recommended preventive services," extends

[88] "Preventive Services," in Healthcare.gov Glossary, available at: https://www.healthcare.gov/glossary/preventive-services/ (accessed November 14, 2014).

[89] "Wellness Programs," in Healthcare.gov Glossary, available at: https://www.healthcare.gov/glossary/wellness-programs/ (accessed November 14, 2014).

[90] "Chronic Disease Management," in Healthcare.gov Glossary, available at: https://www.healthcare.gov/glossary/chronic-disease-management/ (accessed November 14, 2014).

[91] ConnectiCare HMO, p. 25.

[92] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12842 (February 25, 2013) (amending 45 CFR Parts, 147, 155, and 156).

pediatric care to age 21.[93]) Examples of vision care include eye exams and glasses.[94] Dental care includes "visits to a dentist for basic or preventive services, like teeth cleaning, X-rays, and fillings."[95]

Table V.10 *Pediatric Services, including Oral and Vision Care*

State health benefit mandate	Individual	Group
Autism spectrum disorder therapies	§ 38a-488b	§ 38a-514b
Coverage for newborns	*§ 38a-490*	*§ 38a-516*
Birth-to-three Program	§ 38a-490a	§ 38a-516a
Hearing aids for children twelve and under	§ 38a-490b	§ 38a-516b
Craniofacial disorders	§ 38a-490c	§ 38a-516c
Blood lead screening and risk assessment	§ 38a-490d	§ 38a-535
Certain specialized foods	§ 38a-492c	§ 38a-518c
Neuropsychological testing for children diagnosed with cancer	§ 38a-492l	§ 38a-516d
Preventive pediatric care	(group only)	§ 38a-535

Italicized font indicates Connecticut health benefit mandates that do not appear on CCIIO's state-required benefit list.

B. Federal provisions parallel to Connecticut health benefit mandates and other generally applicable federal rules

Federal law contains several health insurance benefit requirement that parallel some of Connecticut's health benefit mandates. In addition, there are some general federal rules, such as anti-age discrimination provisions, limits on cost-sharing levels and benefit limits, that apply to Connecticut's mandated benefits. An overview of these parallel laws and other federal rules, along with a comparison of those requirements to Connecticut's mandated benefits, follows.

1. Federal provisions parallel to certain state health benefit mandates

Some of the federal provisions are incorporated into federal EHB requirements, while others operate independently of the EHB package rules. Some of the provisions, such as preventive services, are newly introduced by the ACA; others, such as mental health parity, pre-date the ACA in substance, but had their applicability extended by the ACA. One identified parallel provision, post-delivery hospital stay, appears to have been little affected by the ACA, though it is included here because of its similarity to, and interaction with, state law. The state health benefit mandates that have parallel federal provisions affect preventive health services, prescription drugs, mental health parity, routine patient care costs during clinical trials, direct access to obstetricians and gynecologists, mothers' and newborns' minimum post-delivery hospital stays, enrollment of newborns, and post-mastectomy reconstructive surgery. [96]

[93] Recommendations for Prevention Pediatric Health Care, 2014. Bright Futures/American Academy of Pediatrics, available at: http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf (accessed January 9, 2014).

[94] "Vision or Vision Coverage," in Healthcare.gov Glossary, available at: https://www.healthcare.gov/glossary/vision-or-vision-coverage/ (accessed November 14, 2014).

[95] "Dental Coverage," in Healthcare.gov Glossary, available at: https://www.healthcare.gov/glossary/dental-coverage/ (accessed November 14, 2014).

[96] There are other Connecticut insurance laws that have parallel federal provisions than those listed; it is beyond the scope of this report to identify all parallel state and federal provisions regulating private insurance. Connecticut's Office of Legislative Review conducted such a study in 2005. See Kaminski J. Overlapping State and Federal Insurance Mandates, Connecticut Office of Legislative Research, 2005-R-0719 (November 25, 2005), available at: http://www.cga.ct.gov/2005/rpt/2005-R-0719.htm (accessed January 21,2015).

Table V.11 lists the Connecticut health benefit mandates that have parallel federal provisions, grouped by type of mandate, and also lists the parallel federal provisions. Where HHS has issued a regulation pursuant to a federal statute, the regulatory section is cited, otherwise the citation is to the relevant section of the United States Code.

Table V.11 *Connecticut Health Benefit Mandates and Parallel Federal Provisions*

Type of provision	State statute (title 38a-)	Federal statute or regulation
Preventive Health Services	503/530 (breast cancer screening) 492k/518k (colorectal screening) 503e/530e (prescription contraceptives) 490d/535 (blood lead screening and risk assessment) 535 (preventive pediatric care)	45 CFR 147.130 (listing sources of "recommended preventive services")
Prescription Drugs	476b (psychotropic drug availability) 483c/513b (experimental treatments) 492b/518b (off-label use of certain drugs) 492c/518c (specialized foods) 492f/518f (drugs removed from formulary) 492i (b)/518i (b) (pain management) 503e/530e (prescription contraceptives) 504 (d)/542 (d) (oral anti-cancer drug parity) 510/544 (mail order pharmacies and step therapy)	45 CFR 156.122
Mental Health Parity	476a (b) (conformity with federal law) 488a/514	45 CFR 146.136
Clinical Cancer Trials	504a et seq./542a et seq.	42 USC 300gg-8
Access to Obstetrician-Gynecologists	503b/530b	45 CFR 147.138 (a) (3)
Mothers' and Newborns' Post-Delivery Hospital Stay	503c/530c	45 CFR 148.170 (ind.) 45 CFR 146.130 (gr.)
Coverage of Newborns	490/516	45 CFR 155.420 45 CFR 146.117 45 CFR 147.104 (b) (2)
Post-Mastectomy Reconstructive Surgery	504 (c)/542 (c) (reconstructive surgery) 504 (a)/542 (a) (prosthetics) 503d/530d (minimum hospital stay)	29 USC 1185b

Table V.12 shows the applicability of the federal provisions to various segments of the private insurance market. The statutory or regulatory location of the substance of the requirement is indicated in the second column. If the provision is a required part of federal EHB or if compliance with the provision otherwise explicitly mentions the Exchange, this is indicated in the third column. The fourth and fifth columns list the regulatory source that obligates individual and group policies to adhere to the provision, regardless of whether they are sold on or off an Exchange. As of January 1, 2014, all of the listed federal provisions apply at least to non-grandfathered individual and small group policies. Several additionally apply to large group policies.

Table V.12 *Federal provisions and applicability*

Benefit	Substance	Exchange	Individual	Group
Preventive Health Services	45 CFR 147.130	45 CFR 156.115(a)(4)	45 CFR 147.130	45 CFR 147.130
Prescription Drugs	45 CFR 156.122	45 CFR 156.115(a)(1)	45 CFR 147.150	45 CFR 147.150 (small group)
Mental Health Parity	45 CFR 146.136(b)(1)	45 CFR 156.115(a)(3)	45 CFR 147.160	45 CFR 146.136(b)(1)
Clinical Cancer Trials	42 USC 300gg-8		42 USC 300gg-8	42 USC 300gg-8
Access to Obstetrician-Gynecologists	45 CFR 147.138 (a) (3)		45 CFR 147.138 (a) (3)	45 CFR 147.138 (a) (3)
Post-Delivery Hospital Stay	45 CFR 146.130 45 CFR 148.170		45 CFR 148.170	45 CFR 146.130
Newborn Coverage	45 CFR 155.420	45 CFR 155.420	45 CFR 147.104	45 CFR 146.117
Post-Mastectomy Surgery	29 USC 1185b		42 USC 300gg-27	42 USC 300gg-27

Note: HHS has not issued regulations for clinical trials coverage, see CCIIO ACA Implementation FAQs Set 15, available at: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html (accessed December 30, 2014). There also do not appear to be regulations for post-mastectomy surgery.

Preventive Health Services

The ACA introduced federal requirements to cover certain preventive health services.[97] These requirements apply directly to group and individual policies.[98,99] Additionally, federally recommended preventive services must be covered in order to be in compliance with federal EHB rules.[100,101,102]

Federal laws, and accompanying regulations, do not themselves prescribe specific preventive health services that must be covered. Instead, federal regulation identifies sources of clinical recommendations and guidelines and requires coverage of the preventive services recommended by those sources;[103] these are referred to as "recommended preventive services."[104] The sources for recommended preventive services are Grade A and B recommendations made by the United State Preventive Services Task

[97] In 2014, a small piece of the federal preventive services mandate was struck down by the United States Supreme Court. *Burwell v. Hobby Lobby Stores, Inc.,* 573 U.S. ___ (2014). The federal preventive services mandate, as originally enacted, contained an exception for religious employers from providing coverage for certain contraceptives. The Supreme Court determined that the definition of religious employers was impermissibly narrow in that it did not allow closely held for-profit business corporations to assert their religious beliefs by claiming the exception. During the same term, the Supreme Court also enjoined HHS from enforcing a notice requirement upon Wheaton College, a religious employer, pending appellate review to determine whether the notice requirement unduly burdened Wheaton College's exercise of religion. See *Wheaton College v. Burwell*, 573 U.S.___ (2014). These legal controversies do not substantially affect the overarching federal preventive services framework.

[98] 45 CFR §147.130.

[99] Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41726, 41728 (July 19, 2010) (amending 45 CFR part 147).

[100] 45 CFR §156.115 (a) (4).

[101] 45 CFR §147.150 (a).

[102] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 77 Fed. Reg. 70644, 70651 (November 26, 2012) (proposed amendments to 45 CFR Parts 147, 155, and 156), final rule at 78 Fed. Reg. 12834 (Feb. 25, 2013).

[103] 45 CFR 147.130.

[104] Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41726, 41728 (July 19, 2010) (amending 45 CFR Part 147).

Force (USPSTF);[105] immunization recommendations promulgated by the Advisory Committee on Immunization Practices (ACIP) at the Centers for Disease Control and Prevention;[106] and comprehensive guidelines for the health of infants, children, and adolescents, and comprehensive guidelines for women's preventive care that are supported by the Health Resources and Services Administration (HRSA).[107] HRSA maintains the Women's Preventive Services Guidelines,[108] which are based on a report by the Institute of Medicine.[109] HRSA has identified two guidelines for infants, children and adolescents:[110] Recommendations for Pediatric Preventive Health by Bright Futures, issued by the American Academy of Pediatrics,[111] and the Uniform Screening Panel of HRSA's Advisory Committee on Heritable Disorders in Newborns and Children.[112]

Some of the relevant recommendations specify frequency, method, or setting for the service. Where these are not specified, the carrier may "rely on established techniques and the relevant evidence base" to determine them.[113] Generally, a recommended preventive service must be included in any health coverage starting one year after the release of the recommendation.[114]

As of October 1, 2014,[115] the USPSTF lists 55 separate preventive services with an A or B grade recommendation.[116] The ACIP currently lists 23 vaccinations for which it has issued guidelines.[117] The 2014 version of Bright Futures' Recommendations for Preventive Pediatric Care lists 26 separate items.[118] The Uniform Panel includes tests for thirty-six conditions,[119] and HRSA's Women's Preventive Services Guidelines lists eight recommended preventive services.[120]

Connecticut does not have a general preventive services mandate, but it does mandate coverage of several

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[105] USPSTF A and B Recommendations (updated October, 2014), available at: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ (accessed November 18, 2014).

[106] Vaccine Recommendations of the ACIP (updated September 19, 2014), available at: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html (accessed November 18, 2014).

[107] 45 CFR §147.130.

[108] HRSA Women's Preventive Services Guidelines (no date), http://www.hrsa.gov/womensguidElines/ (accessed November 18, 2014).

[109] IOM (Institute of Medicine). 2011. Clinical Preventive Services for Women: Closing the Gaps. Washington, DC: The National Academies Press.

[110] Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41726, 41740 (July 19, 2010) (amending 45 CFR Part 147).

[111] Recommendations for Preventive Pediatric Health Care, Bright Futures / American Academy of Pediatrics (2014), available at: http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf (accessed November 18, 2014).

[112] Discretionary Advisory Committee on Heritable Disorders in Newborns and Children, Recommended Uniform Screening Panel (2013), available at: http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf (accessed November 18, 2014).

[113] Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41726, 41728-9 (July 19, 2010) (amending 45 CFR Part 147).

[114] 45 CFR §147.130 (b).

[115] The various sources of recommended preventive services issue recommendations throughout the year. By agreement with CID, CPHHP has only considered federal preventive services that were recommended by October 1, 2014.

[116] USPFTF A and B Recommendations (updated October, 2014), http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ (accessed October 28, 2014).

[117] Vaccine Recommendations of the ACIP (updated September 19, 2014), http://www.cdc.gov/vaccines/hcp/acip-recs/index.html (accessed October 28, 2014).

[118] Recommendations for Preventive Pediatric Health Care, Bright Futures / American Academy of Pediatrics (2014), available at: http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf (accessed November 18, 2014).

[119] Discretionary Advisory Committee on Heritable Disorders in Newborns and Children, Recommended Uniform Screening Panel (2013), available at: http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf (accessed November 18, 2014).

[120] HRSA Women's Preventive Services Guidelines (no date), http://www.hrsa.gov/womensguidElines/ (accessed October 28, 2014).

individual preventive health services. For adults, it requires the coverage of breast cancer screening,[121] colorectal cancer screening,[122] contraceptive prescription drugs,[123] and prostate cancer screening.[124] For children, group and individual policies must cover blood lead screening,[125] and group policies must cover other pediatric preventive health services in addition to blood lead screening.[126]

Breast Cancer Screening

For the purposes of insurance coverage, the current recommendations of the USPSTF regarding breast cancer screening were issued in 2002.[127] The USPSTF recommends that women aged forty or older should be screened for breast cancer with mammography every one to two years.[128] A separate USPSTF recommendation, issued in December 2013,[129] states that women whose family history suggests the possibly of a BRCA gene mutation, which is associated with an increased likelihood of developing breast cancer and other types of cancer, should be screened to determine whether they have such a mutation.[130]

Connecticut law mandates the coverage of a baseline mammogram for women between the ages of 35 and 39 and annual mammograms every year for women aged forty and older.[131] State law also mandates coverage of ultrasound screening for breast cancer for women with dense breast tissue or who may be at increased risk of developing breast cancer as evidenced by personal or family history of breast cancer, genetic test results, and "other indications as determined by a women's physician or advanced practice registered nurse."[132] Finally, MRI scans must be covered for breast cancer screening "in accordance with guidelines established by the American Cancer Society."[133] The American Cancer Society recommends that certain women age forty and older who are at high risk for developing breast cancer should receive an MRI scan every year. The risk factors identified by the ACS include family and personal cancer history, presence of a BRCA gene mutation, presence of the health conditions Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome, or a relative with one of the conditions, or having been subject to radiation therapy to the chest between ages 10 and 30.[134]

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[121] CGS § 38a-503; CGS § 38a-530.

[122] CGS § 38a-492k; CGS § 38a-518k.

[123] CGS § 38a-503e; CGS § 38a-530e.

[124] CGS § 38a-492g; CGS § 38a-518g.

[125] CGS § 38a-490d; CGS § 38a-535.

[126] CGS § 38a-535.

[127] 42 USC § 300gg-13 (a) (5) provides that: "for purposes of this chapter, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009."

[128] United States Preventive Services Task Force (2002). Screening for breast cancer: Recommendations and rationale. *Annals of Internal Medicine,* vol. 137(5): 344-346.

[129] BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing (December, 2013), available at: http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/brca-related-cancer-risk-assessment-genetic-counseling-and-genetic-testing (accessed November 18, 2014).

[130] Moyer V. (2014). Risk assessment, genetic counseling, and genetic testing for BRCA-related cancer in women: US Preventive Services Task Force Recommendation Statement. *Annals of Internal Medicine,* vol. 160(4): 271-282.

[131] CGS § 38a-503; CGS § 38a-530.

[132] CGS § 38a-503; CGS § 38a-530.

[133] CGS § 38a-503; CGS § 38a-530.

[134] American Cancer Society recommendations for early breast cancer detection in women without breast symptoms (updated September 10, 2014), http://www.cancer.org/cancer/breastcancer/moreinformation/breastcancerearlydetection/breast-cancer-early-detection-acs-recs (accessed October 29, 2014).

Table V.13 *Comparison of federal and state breast cancer screening coverage provisions*

Procedure	Federal	State
Baseline mammography	No similar provision	All women ages 35 to 39
Mammography	Every 1 to 2 years for women aged forty and older	Annual for women aged forty and older
Ultrasound	No similar provision	Annual screening for women at increased risk
MRI	No similar provision	Annual for women at high risk
BRCA Genetic Screening	One screening test for certain women with family history suggesting BRCA gene mutation	No similar provision

Federal/State Comparison. Other than BRCA screening coverage, Connecticut mandates coverage for breast cancer screening that is at least as comprehensive as current federal law. Both require coverage of annual mammography screening for women aged forty and older. In addition, Connecticut mandates the coverage of screening by ultrasound and MRI in some cases, whereas federal law does not. The USPSTF is currently reviewing its breast cancer screening recommendations, however, and two of the items on its research agenda include reviewing screening by ultrasound and MRI.[135]

Colorectal Cancer Screening

The current USPSTF recommendation for colorectal screening was released in October of 2008.[136] The USPSTF recommends regular colorectal cancer screening for asymptomatic adults between the ages of 50 and 75 who are not at high risk for developing colorectal cancer. The specific methods of screening recommended are fecal occult blood testing, sigmoidoscopy and colonoscopy. There are no frequency recommendations attached to these screening methods.[137]

Connecticut mandates coverage of colorectal screening "in accordance with the recommendations established by the American Cancer Society" (ACS) and, in addition, specifically mandates coverage of colonoscopy, flexible sigmoidoscopy and radiologic imaging.[138] State law further directs that the frequency and means of screening should be determined after considering "ages, family histories and frequencies provided in the recommendations."[139] The ACS recommends that for adults who are not at high risk for colorectal cancer, regular screening should begin at age 50.[140] Further, it recommends some combination of: a colonoscopy every 10 years; a flexible sigmoidoscopy, a double-contrast barium enema, or a CT colonography every 5 years; and a fecal occult blood test or fecal immunochemical test every year.[141] There are also recommendations for adults who are at various levels of increased or high risk of developing colorectal cancer. Risk factors identified include personal history of colorectal

[135] United States Preventive Services Task Force, Topic Update in Progress: Breast Cancer Screening, http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryDraft/breast-cancer-screening1 (accessed October 29, 2014).

[136] United States Preventive Services Task Force, Colorectal Cancer Screening (October, 2008), http://www.uspreventiveservicestaskforce.org/uspstf14/coloncan/coloncanfinalresplan.htm (accessed October 30, 2014).

[137] U.S. Preventive Services Task Force (2008). Screening for Colorectal Cancer: U.S. Preventive Services Task Force Recommendation Statement. *Annals of Internal Medicine*, vol. 149:627-637.

[138] CGS § 38a-492k; CGS § 38a-518k.

[139] CGS § 38a-492k; CGS § 38a-518k.

[140] American Cancer Society recommendations for colorectal cancer early detection (updated June 6, 2014), http://www.cancer.org/cancer/colonandrectumcancer/moreinformation/colonandrectumcancerearlydetection/colorectal-cancer-early-detection-acs-recommendations (accessed October 30, 2014).

[141] Prior ACS guidelines additionally recommended stool DNA tests, and while this mechanism is still listed, ACS notes that these tests are no longer available. The USPSTF, in 2008, determined that the evidence was insufficient to recommend for or against stool DNA tests.

cancer or adenomatous polyps; a personal history of an inflammatory bowel disease; a family history of colorectal cancer or polyps; or a family history of a hereditary colorectal cancer syndrome. Generally, the risk-level specific recommendations include more frequent screening beginning at a younger age.[142]

Table V.14 *Comparison of federal and state colorectal screening coverage requirements*

Procedure	Federal	State
Age of regular screening for adults not at increased or high risk	50-75	50 or older
Fecal occult blood test	Coverage required, no frequency specified	Annual
Fecal immunochemical test	No provision	Annual
Colonoscopy	Coverage required, no frequency specified	Every 10 years
Flexible sigmoidoscopy	Coverage required, no frequency specified	Every 5 years
Double-contrast barium enema	No provision	Every 5 years
CT colonography	No provision	Every 5 years
Increased and high-risk populations	The USPSTF does not provide specific guidance, but notes that screening at a younger age may be appropriate for some populations	The ACS recommends several specific screening guidelines based on level of risk

Federal/State Comparison. Connecticut law appears to mandate coverage that is at least as comprehensive as federal law. Both require coverage for regular colorectal screening for adults between the ages of 50 and 75, and both specify that this coverage includes screening by fecal occult blood tests, flexible sigmoidoscopy, and colonoscopy. Unlike federal law, the state mandate, by incorporating the recommendation of the ACS, also prescribes specified frequencies of various screening tests and does not provide an upper age limit for regular screening. Additionally, Connecticut law, in accordance with ACS recommendations, requires coverage of screening tests not required by federal law: fecal immunochemical tests, double-contrast barium enemas and CT colonographies and so coverage of these tests is currently in excess of federal law. The USPSTF is reviewing its colorectal recommendations, however.[143] Among other things, the USPSTF will be investigating the efficacy of fecal immunochemical tests and CT colonography.[144]

Contraceptive drugs and devices[145]

Federal coverage requirements for contraceptive drugs and devices are in accordance with HRSA's Women's Preventive Services Guidelines. Federal law requires coverage of FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive

[142] American Cancer Society recommendations for colorectal cancer early detection (updated June 6, 2014), http://www.cancer.org/cancer/colonandrectumcancer/moreinformation/colonandrectumcancerearlydetection/colorectal-cancer-early-detection-acs-recommendations (accessed October 30, 2014).

[143] USPSTF Topic Update in Progress, colorectal cancer screening, http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryDraft/colorectal-cancer-screening2 (accessed October 30, 2014).

[144] USPSTF final research plan screening for colorectal cancer, http://www.uspreventiveservicestaskforce.org/Page/Document/ResearchPlanFinal/colorectal-cancer-screening2 (accessed October 30, 2014).

[145] Both state and federal law have provisions exempting religious employers from the requirement to provide their employees health plans that include the coverage of certain contraceptives. The federal exception has been challenged extensively over the past few years and continues to evolve. Because these provisions govern the responsibility of a small set of employers to provide contraceptive coverage, rather than the scope of contraceptive coverage itself, review of the religious employer exception is beyond the scope of this report.

capacity.[146] Coverage includes over-the-counter drugs when prescribed by a physician.[147]

Connecticut law requires that policies that provide coverage for outpatient prescription drugs must include coverage of "prescription contraceptive methods approved by the Federal Food and Drug Administration."[148]

Federal/State Comparison. In most respects, federal law is more comprehensive than state law. Whereas state law only mandates the coverage of prescription contraceptives, the federal requirements include coverage for contraceptive devices, sterilization procedures and education and counseling. Federal law, however, is specifically limited to women,[149] whereas the Connecticut contraceptives mandate is gender neutral on its face. The FDA has only approved contraceptive prescriptions for women; were it to approve a prescription contraceptive to be taken by men, coverage of that prescription would, presumably, be mandated by state law, but not required by federal law as it currently exists.

Prostate Cancer Screening

The USPSTF reviewed prostate cancer screening most recently in 2012 and assigned a grade D recommendation against screening.[150] Prostate cancer screening is, therefore, not currently required to be covered by federal law.

State law mandates coverage of prostate cancer screening and diagnostic tests for all men older than 50 years, men who are symptomatic, and men whose biological father or brother has been diagnosed with prostate cancer.[151]

Blood Lead Screening and Risk Assessment

Federal law requires the coverage of blood lead screening in accordance with the Recommendations for Preventive Pediatric Health Care produced by Bright Futures.[152,153] Blood lead screening consists of a risk assessment, which uses a set of questions to determine the likelihood that a child has been exposed to lead, and blood testing, which consists of a laboratory test of a sample of blood to determine its lead content. The 2014 Bright Futures Recommendations prescribe blood lead risk assessments at 6 months, 9 months, 12 months, 18 months, 24 months and then annually from age 3 to 6. It also recommends blood lead testing for any child who scores highly on the risk assessment, and blood lead testing at 12 months and 24 months for children at high risk for exposure to lead. In addition to a high score on the risk assessment, high-risk factors include residence in a blood lead poisoning high prevalence area and

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[146] HRSA Women's Preventive Services Guidelines (no date), http://www.hrsa.gov/womensguidElines/ (accessed October 30, 2014).

[147] CCIIO, Affordable Care Implementation FAQs – Set 12: Limitations on Cost-Sharing under the Affordable Care Act; Coverage of Preventive Services (no date), available at: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html (accessed November 18, 2014).

[148] CGS § 38a-503e; CGS § 38a- 530e.

[149] CCIIO Affordable Care Act Implementation FAQ – Set 12 (no date), http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html (accessed October 30, 2014).

[150] Moyer V, and the U.S. Preventive Services Task Force (2012). Screening for Prostate Cancer: U.S. Preventive Services Task Force Recommendation Statement. *Annals of Internal Medicine,* vol. 157:120-134.

[151] CGS § 38a-492g; § 38a-518g.

[152] Recommendations for Preventive Pediatric Health Care (2014), Bright Futures/American Academy of Pediatrics, available at: http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf (accessed November 18, 2014).

[153] The USPSTF reviewed blood lead screening and assigned a grade D recommendation against regular screening. USPSTF Lead Levels in childhood and Pregnancy: Screening (2006), available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspslead.htm (accessed October 30, 2014). Federal law does not, however, account for USPSTF grade D recommendations and, because blood lead screening is part of the recommendations by Bright Futures, coverage for the service is, presumably, federally required.

health insurance provided by Medicaid.[154,155]

State law mandates the coverage of blood lead screening in accordance with recommendations of the Connecticut Childhood Lead Poisoning Prevention Screening Advisory Committee.[156,157,158] Specifically, state law requires coverage of pediatric blood lead screening that primary care physicians are required to perform by other state law. Primary care providers (other than a hospital emergency department and its staff) must annually test children in their care ages 9 to 35 months and children 36 to 72 months who have not previously been screened, or who the physician believes should be tested. As of October 1, 2014, Connecticut also requires physicians to provide educational materials and anticipatory guidance before performing the lead screening.[159]

Table V.15 *Comparison of federal and state blood lead screening frequencies by age*

Procedure	Age	Federal	State
Risk assessment	<36 mo.	6 months, 9 months, 24 months, 18 months	At discretion of physician
	36-72 mo. (3-6 years.)	Annual	Annual
Blood lead test	<9 mo.	6 months if indicated by risk assessment	No provision
	9-35 mo.	9 months if indicated by risk assessment 12 months and 2 years for children at risk or if indicated by risk assessment	Universal annual testing
	36-72 mo. (3-6 years.)	If never previously screened or at risk	If not previously screened, or screening determined appropriate by physician[159]

Federal/State Comparison. State law requires somewhat greater coverage than federal law. Unlike federal law, which limits required routine testing coverage to children meeting one of the high risk factors, Connecticut mandates coverage of testing for all children.

Preventive Pediatric Care (other than blood lead screening)
Federal law mandates the coverage of services recommended by either of two HRSA supported guidelines for infants, children, and adolescents: The Recommendations for Preventive Pediatric Care by Bright Futures and the Uniform Panel of the Advisory Committee on Heritable Disorders in Newborns

[154] 2014 Bright Futures Periodicity Schedule, available at: http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf (accessed December 30, 2014).

[155] Hagan J, Shaw J, Duncan P, eds. (2008) Bright Futures guidelines for health supervision of infants, children, and adolescents (third edition), available at: http://brightfutures.aap.org/pdfs/bf3%20pocket%20guide_final.pdf (accessed December 30, 2014).

[156] CGS § 38a-490d; CGS § 38a-535.

[157] CGS §19a-111g. Enacted October 1, 2014, CGS §19a-111g specifies that children must be "tested" and not merely "screened" at the prescribed frequencies. Public Act 14-231, section 9.

[158] The Advisory Committee does not appear to maintain a website, but information on lead poisoning prevention in Connecticut can be found at "Lead Poisoning Prevention and Control Program" Connecticut Department of Public Health (updated August 27, 2014), available at: http://www.ct.gov/dph/cwp/view.asp?a=3140&q=387550&dphNav_GID=1828&dphPNavCtr=|#47067 (accessed November 18, 2014).

[159] Public Act 14-231, An Act Concerning the Department of Public Health's Recommendations Regarding Various Revisions to the Public Health Statutes, sections 8-9.

[160] Initially, state law mandated coverage for children up to 71 months old. P.A. 14-231 increased the age to 72 months, or 6 years, enacted October 1, 2014.

and Children.[161,162,163] Additionally, federal law mandates the coverage of immunizations recommended by the CDC's Advisory Committee on Immunization Practices (ACIP). The ACIP list of immunizations currently consists of 23 vaccines, including several for infants, children and adolescents.[164] The Uniform Screening Panel for 2013 includes 31 core and 26 secondary disorders that should be screened. The Recommendations of Bright Futures includes preventive services for youth up to age 21 and prescribes an array of services, ranging from very specific items such as measuring the child's height, to services that depend upon professional clinical judgment, such as taking medical histories and conducting physical examinations. The recommendations also cover mental and behavioral health and substance use assessments, in addition to physical and medical assessments. Bright Futures also explicitly incorporates the recommendations of the Uniform Panel and ACIP.

Connecticut law mandates the coverage of preventive pediatric care (other than blood lead screening, which is discussed above) for group policies only. Mandated preventive pediatric care services are those "in keeping with prevailing medical standards" and must be covered for children up to age 6. Connecticut statute specifies that preventive pediatric care includes a child's physical and emotional health, and preventive services "shall include medical history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests."[165] Connecticut law also provides an "approximate" frequency with which these services must be provided. The statutory guidelines are every two months for a child from birth to six months old, every three months for children nine to eighteen months and annually thereafter until the child is six years old.[166]

Federal/State Comparison. State law appears to be less comprehensive than federal law. To the extent that state law recognizes the federal law sources, namely, Bright Futures, the Uniform Panel and the ACIP recommendations, as "prevailing medical practice" the mandated coverage is the same under state and federal law. State law, however, only mandates coverage for children up to 6 years old, whereas federal law appears to require coverage for adolescents up to 21 years old. Further, the minimum frequencies explicitly specified in state statute are less frequent than those listed in the Bright Futures Recommendations.

Prescription Drugs

Any policy that is subject to the requirement to provide EHB must provide coverage for prescription drugs.[167] At a minimum, the policy must cover either one chemically distinct drug in each category and class produced by the United States Pharmacopeia (USP) or the same number of prescription drugs in each USP category and class as covered by the state's EHB-benchmark plan, with the exception of drugs related to abortion services.[168,169] Carriers must also provide insureds a means of obtaining coverage for clinically appropriate drugs that are not otherwise covered by the policy. This includes a process

[161] Bright Futures clinical practice page (no date), http://brightfutures.aap.org/clinical_practice.html (accessed October 30, 2014).

[162] Discretionary Advisory Committee on Heritable Disorders in Newborns and Infants, http://www.hrsa.gov/advisorycommittees/mch-badvisory/heritabledisorders/ (accessed October 30, 2014).

[163] Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41726, 41740 (July 19, 2010).

[164] Vaccine recommendations of the ACIP (updated September 19, 2014), available at: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html (accessed October 30, 2014).

[165] CGS § 38a-535.

[166] CGS § 38a-535.

[167] 45 CFR §156.115 (a) (1) (iii).

[168] 45 CFR §156.122.

[169] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12845 (February 25, 2013) (amending 45 CFR Parts 147, 155, 156).

for expedited review for exigent circumstances.[170] Small group and individual policies must provide the coverage regardless of whether the policies are sold on or off an Exchange.[171] In addition to the general prescription drug requirement, other federal laws may require the coverage of condition-specific prescription drugs. For example, the USPSTF has recently recommended that physicians prescribe certain drugs to women who have certain risk factors for breast cancer.[172] Presumably, carriers must cover these drugs to satisfy the federal preventive services mandate regardless of whether they otherwise provide coverage that satisfies the general prescription drug coverage requirement.

Connecticut does not appear to have a general prescription drug coverage mandate. There are some condition-specific mandates that may include the coverage of prescription drugs within their purview. Connecticut's mandate to cover treatments for Lyme disease, for example, explicitly requires the coverage of "not less than thirty days of intravenous antibiotic therapy, sixty days of oral antibiotic therapy, or both.[173] Several state mandates, however, regulate the manner in which prescription drugs are covered in policies that include such coverage. Carriers that provide prescription drug coverage generally may not require an insured to obtain the prescription drugs through a mail order pharmacy.[174] Carriers may not deny coverage of psychotropic drugs to treat a mental health condition solely on the basis that the drug does not appear on the carrier's formulary, at least when the drug is the most therapeutically effective pharmaceutical treatment.[175] Further, carriers may not deny coverage for a drug as experimental, if the drug has passed an FDA Phase III trial.[176] As noted above, policies that include coverage for outpatient prescription drugs must ordinarily cover prescription contraceptives.[177] When coverage is provided for cancer-fighting drugs, coverage of orally administered drugs must be "no less favorable" than coverage for intravenously administered drugs[178,179] and carriers must also cover off-label use of an otherwise approved drug to treat cancer or a life-threatening chronic disease.[180] When prescription coverage is provided for pain management, carriers may not require an insured first to take alternatives to the prescribed drug, either over-the-counter or alternative brand name drugs, before covering the prescribed drug.[181] Finally, state law mandates the coverage of certain medically specialized foods, including low protein modified food products, amino acid modified preparations and other specialized formulas. The coverage of the specialized foods must be provided "on the same basis as outpatient prescription drugs,"[182] but must be covered even if the policy does not otherwise provide for coverage of outpatient prescription drugs.[183]

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[170] 45 CFR §122 (c).

[171] 45 CFR §147.150.

[172] Breast Cancer: Medications for Risk Reduction (September 2013), http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/breast-cancer-medications-for-risk-reduction (accessed November 19, 2014).

[173] CGS § 38a-492h; CGA § 38a-518h.

[174] CGS § 38a- 510; CGA § 38a-544.

[175] CGS § 38a-476b.

[176] CGS § 38a-483c; CGS § 38a-513b.

[177] CGS § 38a-503e; CGS § 38a-530e.

[178] CGS § 38a-504 (d); CGS § 38a-542 (d).

[179] Leduc J. Anti-Cancer Medication Parity Laws in Select States, Connecticut Office of Legislative Research, 2012-R-0419 (September 12, 2012), available at: http://www.cga.ct.gov/2012/rpt/pdf/2012-R-0419.pdf (accessed November 19, 2014).

[180] CGS § 38a-492b; CGS § 38a-518b.

[181] CGS § 38a-492i (b); CGS § 38a-518i (b).

[182] CGS § 38a-492c; CGS § 38a-518c.

[183] Connecticut Insurance Department, Public Act 04-173 – An Act Concerning Health Insurance Coverage for Medically Necessary Formula. Bulletin HC – 60 (September 24, 2004).

Mental Health Parity

Any policy that is subject to the requirements of EHB must satisfy the federal mental health parity rules.[184,185] In addition, apart from the requirement to satisfy EHB, policies in the group[186] and individual[187] market must comply with federal mental health parity.[188]

The federal mental health parity rules do not require the coverage of any specific benefit, but rather require that policies that offer mental health, behavioral health, or substance use disorder coverage ensure that these benefits are covered in a manner that is not more restrictive than coverage offered for medical and surgical benefits, either by cost-sharing (such as deductible or copays), or in treatment (e.g., days of coverage, number of visits to a health care provider).[189,190] Prior to the ACA, the requirement applied only to group plans. The original provision contains one exception for policies sold to small businesses[191] and another for employers that can demonstrate that providing mental health benefits in parity with medical benefits would increase costs by a specified percent.[192] The ACA extends the mental health parity requirement to those individual and small group policies that must provide EHB and makes the two exceptions unavailable to non-grandfathered plans.[193] Coverage for mental health treatment that is required by the federal preventive health services requirement does not itself trigger the obligation to comply with federal mental health parity.[194]

Connecticut explicitly requires that carriers adhere to the federal mental health parity rules.[195] Further, a section of Connecticut's mental health services benefit mandate independently requires policies to ensure mental health parity.[196] Specifically, this statute provides, in relevant part, that "no such policy shall establish any terms, conditions or benefits that place a greater financial burden on an insured for access to diagnosis or treatment of mental or nervous conditions than for diagnosis or treatment of medical, surgical or other physical health conditions."[197] Connecticut also has a parity provision specific to autism coverage. In group policies, carriers are prohibited from imposing a greater cost-share burden on insureds for accessing autism diagnosis and treatment than for medical, surgical or physical health conditions.[198]

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[184] 45 CFR §156.115 (a) (3).

[185] 45 CFR §147.150.

[186] 45 CFR §146.136 (b).

[187] 45 CFR §147.160.

[188] Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68240, (November 13, 2013) (amending, among other things, 45 CFR Parts 146 and 147).

[189] Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68240, (November 13, 2013) (amending, among other things, 45 CFR Parts 146 and 147).

[190] Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Party and Addiction Equity Act of 2008, 75 Fed. Reg. 5410 (February 2, 2010).

[191] 45 CFR §146.136 (f).

[192] 45 CFR §146.136 (g).

[193] The Center for Consumer Information and Insurance Oversight. The Mental Health Parity and Addiction Equity Act (no date), available at: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html (accessed November 19, 2014).

[194] Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68240, 68244 (November 13, 2013) (amending, among other things, 45 CFR Parts 146 and 147).

[195] CGS § 38a-476a.

[196] Unlike federal law, which, outside of the EHB package rules, does not require the coverage of any particular mental health condition, Connecticut requires the coverage of nearly all mental health conditions identified in the DSM, with a few statutory exceptions. CGS § 38a-488a; § 38a-514.

[197] CGS § 38a-488a; CGS § 38a-514.

[198] CGS § 38a-514b (e).

Federal/State Comparison. Because Connecticut incorporates federal law by reference, Connecticut requires mental health parity that is at least as comprehensive as federal law. Connecticut's independent parity requirement appears largely similar to the federal requirement. Because state law focuses on the financial burden to the insured, rather than coverage provided, however, it is possible that in some instances state law may be more consumer friendly than federal law.[199,200] Further, Connecticut law does not contain the two federal exceptions to mental health parity, i.e., for small groups and policies for which provision of mental health parity would be especially costly.[201] The Connecticut mandate also does not appear to ignore benefits that are covered solely to comply with the federal preventive services requirements when determining compliance with mental health parity.

Clinical Trials

Federal law provides that carriers may not deny coverage for routine patient costs of care arising from clinical trials when those costs would otherwise be covered if incurred in a non-trial clinical setting.[202,203] To enjoy the protection of federal law, insureds may be required to show that they are eligible to participate in the trial, and that the cost of care for which coverage is sought is within the meaning of "routine patient costs." In addition, the insured may be required either to show that a referring physician concluded that participation in the trial is appropriate, or to furnish medical and other evidence that participation in the trial is appropriate. The trial itself may be a phase I, II, III, or IV trial and must be approved of by one of the entities listed in Table V.16.

Connecticut law mandates that carriers cover the costs of routine patient care arising during the course of a clinical trial if those costs would otherwise be covered.[204] Under state law, the insured may be required to demonstrate suitability for participation in the trial and that the trial satisfies the state definition of a clinical trial. State law lists a number of different sources of evidence that carriers may require of insureds before covering routine care costs arising from a clinical trial (see Table V.16). Carriers may limit coverage to a phase III trial that is approved by one of the listed entities.

[199] Leduc J, Required Insurance Coverage for Mental Health Services, Connecticut Office of Legislative Research, 2009-R-0415 (November 6, 2009), available at: http://www.cga.ct.gov/2009/rpt/2009-R-0415.htmv (accessed November 19, 2014).

[200] Leduc J, Mental Health Parity, Office of Legislative Research, 2013-R-0086 (January 25, 2013), available at: http://www.cga.ct.gov/2013/rpt/2013-r-0086.htm (accessed November 19, 2014).

[201] Kaminski J (2005). Overlapping State and Federal Insurance Mandates, Connecticut Office of Legislative Review, 2005-R-0719.

[202] 42 USC § 300gg-8.

[203] The Center for Consumer Information & Insurance Oversight. Affordable Care Act Implementation FAQs – Set 15 (no date), available at: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html (accessed November 29, 2014).

[204] CGS § 38a-504a *et seq.*; CGS § 38a- 542a *et seq.*

Table V.16 *Comparison of federal and state clinical trials coverage requirements*

Basic benefit	Federal	State
	Coverage required of routine patient care costs	Coverage required of routine patient care costs
Access to trials	Carriers may not deny access to clinical trials	No explicit provision
Routine patient care costs	Costs that are typically covered	Costs that are typically covered
Eligible individual	• Meets clinical trial criteria *and either* • The referring health provider has concluded participation is appropriate • Evidence of medical and scientific information establishing that individual's participation is appropriate	• Meets clinical trial criteria *and provides* • Evidence of consent • Copies of medical records, protocols, test results or other clinical information used by the enrolling physician • Anticipated routine care costs in excess of costs for standard treatment • Information on other sources of coverage for routine care costs • "[A]ny additional information that may be reasonably required"
Clinical trial	Phase I, phase II, phase III or phase IV clinical trial for "cancer or other life-threatening disease or condition"	Phase III clinical trial for "cancer or disabling or life-threatening chronic diseases in human beings"
Listed entities	• The National Institutes of Health • The Center for Disease Control and Prevention • The Agency for Health Care Research and Quality • The Centers for Medicare & Medicaid Services • The Department of Defense • The Department of Veterans Affairs • The Department of Energy • A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants	• The National Institutes of Health • A National Cancer Institute affiliated cooperative group • The federal Food and Drug Administration as part of an investigational new drug or device application or exemption • The federal Department of Defense • The federal Department of Veterans Affairs

Federal/State Comparison. State law and federal law appear to cover the same benefit, i.e., routine care costs. State law may allow carriers to be more restrictive in how that benefit is covered. Federal law requires carriers to accept either evidence of medical suitability to participate in the trial or the conclusion of a referring physician. State law does not require a carrier to allow the insured to shortcut the evidentiary requirement by providing professional medical judgment, but rather allows the carrier to require evidence of medical suitability in all cases. Further, state law appears restricted to mandating coverage of routine care costs arising in phase III trials, whereas federal law requires coverage for phases I, II, III and IV. Finally, the list of entities that may approve the trial is more expansive under federal law than Connecticut law.[205]

Access to Obstetricians and Gynecologists

Federal law prohibits any health insurance issuer offering group or individual health insurance coverage from requiring a woman to secure prior authorization before seeking obstetrical or gynecological care from a participating in-network health care professional who specializes in obstetrics or gynecology.[206] A "professional who specializes in obstetrics or gynecology" is any such professional who is authorized to provide such care under applicable state law.[207]

Connecticut law mandates that group and individual policies allow direct access to a participating in-network obstetrician or gynecologist for obstetrical or gynecological care.[208]

Federal/State Comparison. Federal and state law appear to be substantially similar, though federal law refers generally to obstetrical-gynecological care, whereas Connecticut describes the covered care in two components: care related to childbirth and other gynecological care.

Newborns' and Mothers' Post-delivery Hospital Stay

Federal law requires that policies that cover maternity benefits must provide coverage of at least 48 hours of hospital stay for both the mother and infant after the newborn is delivered.[209] This requirement applies to both individual[210] and group[211] coverage. It predates the ACA for both group and individual coverage.[212] The mandated minimum stay increases to 96 hours when the newborn is delivered by Cesarean section. When the newborn is delivered in a hospital, the minimum hospital stay period begins upon delivery. If the child is born outside of a hospital, then the hospital stay begins at the time the mother or newborn is admitted as an inpatient "in connection with the childbirth." The care provider, rather than the insurance carrier, determines when a hospital admission is in connection with childbirth. Federal law specifically provides that if a state law mandates "comparable coverage," federal law does not operate on policies subject to that state's law. "Comparable coverage" includes "coverage to provide at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by Cesarean section."

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[205] Both state law and federal law also provide various rules on coverage for clinical trials that are offered by physicians in-network and out-of-network, with each listing various examples. These rules also differ somewhat.

[206] 45 CFR §147.138 (a) (3).

[207] Patient Protection and Affordable Care Act; Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37188, 37194 (June 28, 2010).

[208] CGS § 38a-503b; CGS § 38a-530b.

[209] Final Rules for Group Health Plans and Health Insurance Issuers Under the Newborns' and Mothers' Health Protection Act, 73 Fed. Reg. 62410 (October 20, 2008).

[210] 45 CFR §148.170.

[211] 45 CFR §146.130.

[212] Final Rules for Group Health Plans and Health Insurance Issuers Under the Newborns' and Mothers' Health Protection Act, 73 Fed. Reg. 62410 (October 20, 2008).

Connecticut law mandates that carriers providing coverage for maternity-related hospital stay provide the coverage of a minimum hospital stay of 48 hours after delivery and 96 hours after delivery by Cesarean section.[213] If the physician and mother determine that the mother and infant may safely be discharged before the minimum stay is completed, state law also mandates that a follow-up visit shall be covered if the follow-up visit occurs within 48 hours of discharge and a subsequent follow-up visit must be covered if it occurs within 7 days of discharge. There is no provision governing mandatory coverage if the delivery occurs outside a hospital setting.

Federal/State Comparison. State and federal law require coverage of the same basic benefit, a hospital stay of 48 hours after delivery and 96 hours after Cesarean delivery. In addition, Connecticut law provides that a mother or infant who is discharged before the expiration of the mandatory minimum stay period is entitled to coverage of follow-up visits. Because Connecticut law appears to satisfy the federal requirement of 48/96 hours minimum stay period, federal law presumably does not operate upon policies subject to Connecticut law and, therefore, any additional protections offered by the federal law are not required in this state.[214]

Coverage for Newborns

Federal law guarantees insureds the ability to enroll their newborn children for coverage under a health policy sold through an Exchange,[215] or outside of the Exchange in the group[216] or individual[217] market. Exchanges are required to ensure that coverage for newborns is effective from the date of birth, or later at the option of the insured. The Exchanges must also provide insureds a 60-day special enrollment period in which to enroll their newborns. A policy sold in the individual market off the Exchange must offer a "limited enrollment period" for births and other reasons. The limited enrollment period for births is subject to the same terms as the policies sold on the Exchange, and, therefore, insureds with individual polices also have a 60 day period to enroll their newborns. Group policies sold off the Exchange also must allow special enrollment periods for newborns, but insureds are only guaranteed a minimum of 30 days in which to enroll them. Federal law preempts state law only to the extent that state law frustrates the operation of the federal provision. States are free to adopt laws that provide stronger consumer protections than the parallel federal law.[218]

Connecticut mandates that group[219] and individual[220] policies that include coverage for family members of an insured shall cover a newly born child from the moment of birth and for 61 days following. The newborn shall enjoy the same coverage as available to any child under the policy. State law mandates that carriers allow insureds 61 days to provide notice of birth and fulfill any other requirements to ensure coverage for the newborn continues after the first 61 days.

Federal/State Comparison. Connecticut law appears to provide stronger consumer protections than federal law. Most noticeably, state law mandates coverage of newborns from the moment of birth, whereas federal law only guarantees the ability to enroll a newborn at the time of birth, though, once

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213 CGS § 38a-503c; CGS § 38a-530c.

214 Final Rules for Group Health Plans and Health Insurance Issuers Under the Newborns and Mothers' Health Protection Act, 73 Fed. Reg. 62410, 62413 (October 20, 2008) (amending, among other things, 45 CFR Parts 144, 146, and 148).

215 45 CFR §155.420.

216 45 CFR §146.117 (b) (2) (iv).

217 45 CFR §147.104 (b) (2).

218 Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review; Final Rule, 78 Fed. Reg. 13406, 13417 (February 27, 2013).

219 CGS § 38a-516.

220 CGS § 38a-490.

enrolled, coverage is guaranteed from the time of birth. Further, Connecticut requires carriers to provide more time to enroll a newborn than federal law. In Connecticut, insureds have 61 days to notify the carrier of the newborn and fulfill any requirements necessary to ensure coverage for the newborn past the initial 61 days. This is true whether coverage is under an individual or group policy. Under federal law, carriers must allow 60 days to enroll a newborn in individual plans; for group plans they are only required to give insureds 30 days.

Reconstructive Surgery Following Mastectomy

Federal law requires plans that cover mastectomies to also provide coverage for reconstructive surgery after a mastectomy.[221] Initially, this requirement only applied to group plans, but the ACA extended it to the individual market.[222] Federal law requires coverage for "all stages of reconstruction of the breast on which the mastectomy has been performed" as well as surgery on the other breast to produce a symmetrical appearance. It further requires coverage for prostheses and any treatment for physical complications of the mastectomy.[223]

Connecticut law mandates coverage for reconstructive surgery for the breast subject to mastectomy, and reconstructive surgery on the other breast.[224] Connecticut law mandates the coverage of prosthetic devices for all tumor treatments;[225] presumably this includes prosthetic devices used in the treatment of breast cancer. In a separate statutory section, Connecticut also requires carriers to cover at least 48 hours of inpatient hospital stay following a mastectomy or lymph node dissection. The mandated coverage period may be longer, if a longer period is recommended by the patient's treating physician.[226]

Federal/State Comparison. Connecticut law requires more comprehensive benefits than federal law regarding this benefit; state law mandates coverage of minimum hospital stays following a mastectomy.

Mail order pharmacies

In November of 2014, HHS proposed a rule prohibiting carriers from requiring, in most cases, insureds to purchase their drugs through mail order pharmacies.[227] If this proposed rule becomes final, the resulting regulation would be similar to Connecticut's prohibition.[228]

2. Generally applicable federal rules

Other federal rules that are not benefit-specific may be applicable to components of several mandates, including age limits, annual and lifetime benefit limits, and cost-sharing.

Federal Age-Discrimination and State Mandate Age Limits

Policies sold through the Exchange, and other policies subject to the requirement to cover an EHB package, must not discriminate based on, among other things, an insured's age.[229] A policy may,

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[221] 29 USC §1185b.

[222] 42 USC § 300gg-27.

[223] CCIIO Women's Health and Cancer Right Act (no date), http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html (accessed October 31, 2014).

[224] CGS § 38a-504 (c); CGS § 38a-542 (c).

[225] CGS § 38a-504 (a); CGS § 38a-542 (a).

[226] CGS § 38a-503d; CGS § 38a-530d.

[227] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 79 Fed. Reg. 70674, 70722 (November 26, 2014).

[228] CGS § 38a-510; § 38a-544.

[229] 45 CFR §156.125.

however, continue to employ "reasonable medical management techniques" to make coverage determinations.[230] It appears that coverage may be limited to specific ages without violating the anti-discrimination rules if the covered treatment is only clinically effective for the specified ages.[231] Indeed, one of the EHB categories, pediatric services, appears to presuppose that some benefits will only be required for the pediatric population. In the preamble to a recent proposed rule, however, HHS has stated that "age limits are discriminatory when applied to services that have been found clinically effective at all ages" and that the anti-discrimination rules should not be circumvented by "labeling the benefit as a 'pediatric service,' thereby excluding adults."[232] HHS has also provided, as an example, that "it would be arbitrary to limit a hearing aid to enrollees who are 6 years of age and younger since there may be some older enrollees for whom a hearing aid is medically necessary."[233] Twelve Connecticut health benefit mandates have age provisions that either appear in the mandate itself or, in the case of blood lead screening, appear in a separate statutory section referenced by the mandate. These mandates are listed in Table V.17. To the extent that some of Connecticut's mandates require coverage for certain age groups only, compliance with state law may not ensure compliance with federal law, if those age limits are not based on medical effectiveness.

Eleven of these state mandates that include ages appear on CCIIO's list of state-required benefits. Two are preventive services aimed at adults and include minimum age requirements for mandatory coverage. A third mandate, infertility treatment, is also aimed at adults but has an age maximum of 40 years. The other eight mandates with age limits are aimed at children and include various age maxima ranging from 3 years to 18 years. One mandate specifies only that it requires coverage for "children" without specifying any particular age. What follows is a list that includes Connecticut's health benefit mandates with explicit age provisions. No attempt is made here to evaluate the medical justification for the statutory ages.

[230] 45 CFR §156.125 (c).

[231] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 79 Fed. Reg. 70674, 70722-70723 (proposed amendments to 45 CFR Parts 144, 146, 147 *et al.*) (November 26, 2014).

[232] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 79 Fed. Reg. 70674, 70722-70723 (proposed amendments to 45 CFR Parts 144, 146, 147 *et al.*) (November 26, 2014).

[233] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 79 Fed. Reg. 70674, 70722-70723 (proposed amendments to 45 CFR Parts 144, 146, 147 *et al.*) (November 26, 2014).

Table V.17 *Connecticut health benefit mandates with age criteria.*

State benefit description	Individual	Group	Age coverage requirement
Autism spectrum disorder therapies	No age restriction	§ 38a-514b	15 years and under, for behavioral therapy in group policies
Coverage for newborns	*§ 38a-490*	*§ 38a-516*	*61 days and under*
Birth-to-three	§ 38a-490a	§ 38a-516a	3 years and under
Hearing aids for children twelve and under	§ 38a-490b	§ 38a-516b	12 years and under
Craniofacial disorders	§ 38a-490c	§ 38a-516c	18 years and under
Blood lead screening and risk assessment	§ 38a-490d	§ 38a-535	6 years and under
Certain specialized foods	§ 38a-492c	§ 38a-518c	12 years and under for specialized formulas
Prostate cancer screening and treatment	§ 38a-492g	§ 38a-518g	50 years and over for men who are asymptomatic and not at high risk
Neuropsychological testing for children diagnosed with cancer	§ 38a-492l	§ 38a-516d	"child"
Breast cancer screening	§ 38a-503	§ 38a-530	35 years for a base-line mammography, and 40 years and over for screening
Infertility diagnosis and treatment	§ 38a-509	§ 38a-536	40 years and under
Preventive pediatric care	(group only)	§ 38a-535	Child/6 years and under

Italicized font indicates that the mandate does not appear on CCIIO's list of Connecticut required benefits.

Annual and Lifetime Benefit Limits

As of the plan years starting January 1, 2014, federal law prohibits individual and group policies from applying annual or lifetime limits on the dollar amount to any individual insured or any essential health benefit. Carriers may continue to place annual and lifetime dollar amount limits on specific benefits that are not essential health benefits, unless otherwise prohibited by federal or state law.[234,235] Carriers are not prohibited from applying non-dollar limits to essential health benefits.

Connecticut law prohibits carriers from imposing a lifetime limit on the dollar value of benefits for an insured or for an essential health benefit, as defined by the ACA and accompanying regulations.[236] Additionally, several of Connecticut's health benefit mandates independently limit carriers' discretion to impose lifetime limits, annual limits, or both. Most of these rules prohibit the carriers from imposing specific limits on dollar values of the benefits, though four of the mandates prohibit carriers from imposing certain service provision limits.

[234] 45 CFR §147.126.

[235] Patient Protection and Affordable Care Act; Requirements for Group Health Plans and Health Insurance Issuers under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final and Proposed Rule, 75 Fed. Reg. 37188, 37190-37191 (June 28, 2010).

[236] CGS § 38a-482c; § 38a-512c.

Table V.18 *Annual and lifetime benefit limits.*

Mandate	Individual	Group	Annual	Lifetime
Birth-to-three	§ 38a-490a	§ 38a-516a	$6,400	$19,200
Hearing aids for children twelve and under	§ 38a-490b	§ 38a-516b	$1,000 (per 24 months)	None specified
Accidental ingestion of controlled drugs	§ 38a-492	§ 38a-518	30 days inpatient hospital stay; $500 for services received other than as an inpatient	None specified
Ostomy-related supplies	§ 38a-492j	§ 38a-518j	$2,500	None specified
Bone marrow testing	§ 38a-492o	§ 38a-518o	None specified.	One test
Home health care	§ 38a-493	§ 38a-520	80 home health care visits; $200 for medical social services for terminally ill with a prognosis of 6 months or less to live	None specified
Tumors and leukemia	§ 38a-504	§ 38a-542	$500 for surgical removal of tumors; $300 for surgical removal of each breast removed due to tumors; $500 for reconstructive surgery; $500 for outpatient chemotherapy; $350 for a wig; $300 for prosthesis; $1,000 for removal of a breast implant (group only)	None specified
Infertility diagnosis and treatment	§ 38a-509	§ 38a-536	None specified.	Ovulation induction limited to four cycles. Intrauterine insemination limited to three cycles. Limit two cycles for in-vitro fertilization, gamete intra-fallopian transfer and low tubal ovum transfer.

Table V.18 *Annual and lifetime benefit limits.*

Mandate	Individual	Group	Annual	Lifetime
Autism spectrum disorder therapies	(group only)*	§ 38a-514b	$50,000 for a child <9 years; $35,000 for a child 9 to 12; $25,000 for a child 13-14 No limits on number of visits to an autism services provided pursuant to a treatment plan other than for lack of medical necessity	None specified

* The autism spectrum disorder therapies mandate applies to both individual and group policies. There are somewhat more requirements for group policies than for individual policies. The provision cited here applies only to group policies.

Pursuant to the benchmark plan method of defining EHB, all of the health benefit mandates listed in the table above are essential health benefits in Connecticut, and, therefore, carriers may not impose annual or lifetime dollar amount limits on any of them. Connecticut's Insurance Department has issued particular guidance on benefit limits specific to autism coverage, in which it directs all carriers to remove all limits, dollar or otherwise, from their applied behavioral analysis benefits.[237]

Cost-Sharing

Federal law imposes certain cost-sharing rules[238] for the coverage of EHB on individual and small group policies, whether they are sold on[239,240] or off[241] the Exchange. A cost-share consists of a co-payment, coinsurance, deductible or other out-of-pocket expense paid by an insured, other than premium amounts or balance billing amounts for non-network providers.[242] Generally, the ACA does not prohibit cost-sharing, but it does limit the total cost-share that an insured may be required to pay within a policy year.[243] For plan year 2014, the first year in which the cost-share rules became effective for individual and small group policies, the particular amounts that a carrier could require the insured to pay for cost-sharing was $6,350 for self-only coverage and double that, or $12,700, for family coverage.[244,245] These amounts are tied to the cost-share limits included in the definition of high deductible health plans in the internal revenue code,[246] which the Internal Revenue Service annually adjusts for inflation.[247,248,249] For plan years after 2014, HHS provides a means of adjusting premiums and calculating adjusted cost-share

[237] Connecticut Insurance Department, Health Insurance Coverage for Autism Spectrum Disorders and Early Intervention Services, Bulletin HC-99 (August 20, 2014).

[238] 45 CFR §156.130.

[239] 45 CFR §156.200 (b).

[240] 45 CFR §156.20.

[241] 45 CFR §147.150 (a).

[242] 45 CFR §155.20.

[243] 45 CFR §156.130.

[244] CCIIO Affordable Care Act Implementation FAQs – Set 18, available at: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html (accessed December 17, 2014).

[245] Rev. Proc. 2013-25, Internal Revenue Bulletin 2013-21 (May 20,2013), available at: http://www.irs.gov/irb/2013-21_IRB/ar08.html (accessed December 17, 2014).

[246] 45 CFR §156.130 (a).

[247] 26 USC 223 (c) (2) (A) (ii).

[248] E.g., Rev. Proc. 2013-25, Internal Revenue Bulletin 2013-21 (May 20,2013), available at: http://www.irs.gov/irb/2013-21_IRB/ar08.html (accessed December 17, 2014).

[249] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 77 Fed. Reg. 70644, 70653 (proposed rule) (November 26, 2012).

amounts based on that premium adjustment.[250]

For policies sold on the Exchange, some insureds will be eligible for reduced cost-sharing, including those who earn between 100 and 150 percent of the federal poverty level;[251] 150 and 200 percent of the FPL;[252] 200 and 250 percent of the FPL;[253] and some insureds who meet the federal definition of Indian.[254] For non-Indian insureds, reduced cost-sharing is only available in silver-level Qualified Health Plans.[255]

Initially, special rules applied to limit the amount of deductibles that small group policies could require insureds to pay. These were later repealed by Congress and the accompanying regulations were eliminated.[256,257,258,259]

In addition to these general rules that limit cost-sharing amounts charged for all essential health benefits, there are more specific rules regarding coverage of preventive health services and emergency services. Federally-required recommended preventive health services must be provided without cost-sharing,[260] unless those services are provided at an office visit in conjunction with other services, the primary reason for the visit was to obtain the other services, and the services are billed together.[261] States are free to require more comprehensive preventive health services than federal law.[262] Presumably, when a state-required benefit is more comprehensive than the federally required counterpart, the prohibition of cost sharing applies only to the coverage required by federal law, though this is not explicitly stated in the regulations. Cost-sharing for emergency services is also specially regulated. Any emergency service provided out-of-network is generally limited to the same cost-sharing limits as emergency services provided in-network.[263,264] If, however, the out-of-network services are more costly to the carrier than in-network services, the insured can also be charged for the excess cost.[265]

Connecticut does not have a provision that limits cost-sharing generally, but five health benefit mandates, enacted as of October 1, 2014, include such a provision. Two additional mandates limit cost-sharing, effective January 1, 2015.

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[250] 45 CFR §156.130 (a) (2).

[251] 45 CFR §155.305 (g) (2) (i).

[252] 45 CFR §155.305 (g) (2) (ii).

[253] 45 CFR §155.305 (g) (2) (iii).

[254] 45 CFR §155.350 (a).

[255] 45 CFR §155.305 (g).

[256] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834,12847-8 (February 25, 2013).

[257] Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond, 79 Fed. Reg. 30240, 30313 (May 27, 2014).

[258] Public Law 113-93, "Protecting Access to Medicare Act of 2014."

[259] 45 CFR §156.130 (b).

[260] 45 CFR §147.130 (a) (1).

[261] 45 CFR §147.130 (a) (2).

[262] Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protect ion and Affordable Care Act, 75 Fed. Reg. 41726, 41728 (July 19, 2010).

[263] 45 CFR §156.130 (g).

[264] 45 CFR §147.138 (b) (3).

[265] 45 CFR §147.138 (b) (3).

Table V.19

Mandate	Individual	Group	Cost-share limit	Applicability to high deductible health plans
Enacted as of October 1, 2014				
Birth-to-three	§ 38a-490a	§ 38a-516a	No coinsurance, co-payment, deductible or other out-of-pocket expense for such services	Deductible limit not applicable
Colorectal cancer screening	§ 38a-492k	§ 38a-518k	No deductible for a screening colonoscopy or a screening sigmoidoscopy No coinsurance, co-payment, deductible or other out-of-pocket expense for any additional colonoscopy ordered within the policy year	Not applicable
Bone marrow testing	§ 38a-492o	§ 38a-518o	Coinsurance, co-payment, deductible or other out-of-pocket expense limited to 20 percent of the cost for such testing per year	Not applicable
Home health care	§ 38a-493	§ 38a-520	Annual deductible limited to $50 per person Coinsurance limited to 25 percent	Deductible limit not applicable
Co-payments regarding in-network imaging services	§ 38a-511	§ 38a-550	MRI and CAT co-payments limited to $75 per scan and $375 per year (in-network) PET co-payment limited to $100 per scan or $400 per year (in-network)	Not applicable
Enacted January 1, 2015				
Breast Cancer Screening	§ 38a-503	§ 38a-530	Co-payment for ultrasound screening limited to $20	Applicable
Co-payments for physical therapy and occupational therapy	§ 38a-511a	§ 38a-550a	Physical therapy and occupational therapy co-payments limited to $30	Applicable

In addition, state law has also incorporated several parts of the ACA by reference.[266] Connecticut law explicitly references sections 2701 to 2709 of the Public Health Services Act, as amended by the ACA. These sections apply the EHB package requirements, including cost-sharing requirements, to individual and small group policies, whether sold on or off Exchanges.

C. State-required benefits in excess of essential health benefits and state liability

Federal law does not prohibit the states from continuing to adopt and enforce health benefit mandates.[267] If state law requires Qualified Health Plans (QHPs) to include state-required benefits that are in addition to EHB, however, states must defray the cost of covering those benefits.[268] This cost-defray liability extends only to QHP policies sold on the Exchanges.[269] The Exchanges have been authorized to determine, in the first instance, whether a state-required benefit is in excess of EHB.[270]

What constitutes a state-required health benefit in excess of EHB depends, in part, on the content of federal EHB rules. For the 2014 and 2015 plan years, EHB is determined state-by-state pursuant to the benchmark method described above. A state is not liable to defray the cost of requiring any benefit that was covered by the state's EHB-benchmark plan, because those benefits are EHB in that state. Additionally, a state is not liable to defray the cost of any state-required benefit enacted prior to December 31, 2011, regardless of whether that benefit was covered by the benchmark plan.[271]

State liability for plan years beginning in 2016 and beyond has not yet been determined by HHS. However, on November 26, 2014, HHS released a proposed rule focusing on benefits for the 2016 plan year, though also touching somewhat upon the 2017 plan year.[272] The preamble to the proposed rule does not explicitly state that HHS intends to keep the current benchmark plans as the definition of EHB in the states for plan year 2016, though the absence of any proposed alternative definition for plan year 2016 suggests that this will be the case. HHS does propose allowing states to choose a new benchmark plan to serve as the basis of EHB for plan year 2017. The proposed selection method largely follows the method states used to select their current benchmark plans, though the reference plan options would be from plan year 2014.[273] HHS did not directly address state cost-defray liability in its proposed rule.

Whether a state-required benefit is in excess of EHB also depends, in part, on the definition of "state-required benefit." According to HHS, a state-required benefit is one which mandates the coverage of "specific care, treatment, or services."[274,275] HHS considered whether to require states to defray the costs

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[266] CGS § 38a-591.

[267] 45 CFR §155.170 (a) (1) ("A state may require a QHP to offer benefits in addition to the essential health benefits.").

[268] 45 CFR §155.170 (b).

[269] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12838 (February 25, 2013).

[270] 45 CFR §155.170 (a) (3).

[271] 45 CFR §155.170 (a) (2).

[272] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 79 Fed. Reg. 70674 (November 26, 2014).

[273] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 79 Fed. Reg. 70674, 70718 (November 26, 2014).

[274] Center for Consumer Information & Insurance Oversight, Guide to Reviewing Essential Health Benefits Benchmark Plans (no date), available at: http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html#review benchmarks (accessed November 4, 2014).

[275] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12838 (February 25, 2013).

arising from any law regulating an insurance policy sold on an Exchange, and rejected this possibility.[276] HHS has provided several examples of types of laws governing health insurance that do not meet the definition of state-required benefit, and, thus, would not trigger state cost-share liability. These include: 1) provider mandates, which do not require the coverage of any particular service but rather require that reimbursement be paid to specified types of providers when performing otherwise covered services; 2) cost-sharing rules; 3) delivery methods, such as laws regarding coverage of telemedicine; and 4) dependent-coverage mandates, such as laws requiring coverage of newborns, adopted children, domestic partners and disabled children.[277,278,279]

Some specifically-identified health benefits are prohibited from being included in the definition of EHB, including routine non-pediatric dental services; routine non-pediatric eye exam services; long-term and custodial nursing home care benefits; and non-medically necessary orthodontia.[280] Therefore, a state mandate to provide any of these services would be considered to be in excess of EHB and subject to the cost defray rule.

Connecticut's definition of health benefit mandate is broader than the federal definition of state-required benefits.[281] Among other things, Connecticut mandates specifically include a number of provider mandates, cost-sharing rules[282] and dependent coverage laws.[283] The federal Center for Consumer Information and Insurance Oversight (CCIIO) has produced a list of Connecticut laws that it deems to be state-required benefits.[284] This list includes thirty-eight provisions. With one exception, wound care for epidermolysis bullosa,[285] all of these have been previously reviewed by CPHHP. The full list of Connecticut health benefit mandates, with those that appear on CCIIO's list of Connecticut-required benefits identified, appear in Appendix II.

Connecticut health insurance benefit mandates that have been reviewed by CPHHP, but do not appear on CCIIO's list of Connecticut-required benefits, are provided in table V.21. These mandates do not, presumably, meet the federal definition of state-required benefit and so they are not subject to the cost-defray rules.

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[276] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12838 (February 25, 2013).

[277] Center for Consumer Information & Insurance Oversight, Guide to Reviewing Essential Health Benefits Benchmark Plans (no date), available at: http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html#review benchmarks (accessed December 2, 2014).

[278] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12838 (February 25, 2013).

[279] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 77 Fed. Reg. 70644, 70633 (November 26, 2012).

[280] 45 CFR §156.115 (d).

[281] CGS § 38a-21.

[282] Chapter 9 "Co-payments regarding in-network imaging services," in CPHHP Connecticut Mandated Health Insurance Benefit Reviews 2010, vol. IV.

[283] Chapter 7 "Coverage for newborn infants in health insurance policies," in CPHHP Connecticut Mandated Health Insurance Benefit Reviews 2010, vol. II.

[284] Connecticut – State-required benefits, available at: http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/ct-state-required-benefits.pdf (accessed December 3, 2012).

[285] CGS § 38a-492n; § 38a-518m.

Table V.20 *Reviewed Connecticut Health Benefit Mandates that are not on CCIIO's list of Connecticut-required benefits*

State benefit description	Individual	Group	Characterization
Coverage for newborns	38a-490	38a-516	Dependent
Prescription drugs removed from formulary	38a-492f	38a-518f	Miscellaneous
Mobile field hospital	38a-498b	38a-525b	Delivery method
Elevated blood alcohol content	38a-498c	38a-525c	Delivery method/provider
Services of physician assistants and certain nurses	38a-499	38a-526	Provider
Services provided by the Veterans' Home	38a-502	38a-529	Delivery method
Direct access to obstetrician-gynecologists	38a-503b	38a-530b	Delivery method/provider
Chiropractic services	38a-507	38a-534	Provider
Co-payments regarding in-network imaging services	38a-511	38a-550	Cost-sharing
Rehabilitative services (mandatory offer)	(group only)	38a-523	Mandatory offer, not a mandated benefit
Maternity benefits and pregnancy care following policy termination	(group only)	38a-547	Coverage eligibility

CCIIO has not provided the reasons for its determination that some Connecticut mandates are Connecticut-required benefits, and others are not. Table V.21 makes some attempt to characterize the state laws that do not appear on CCIIO's list. Where HHS has identified particular types of insurance rules that do not meet the federal definition of state-required benefit, and state mandates in table V.21 appear to match those categories, the mandates have been characterized accordingly. Three of the mandates that did not make CCIIO's list might be characterized as provider mandates: Connecticut requires that carriers provide reimbursement to obstetrician-gynecologists, physician assistants and certain nurses, and chiropractors. One of the reviewed mandates may be characterized as a dependent-coverage mandate: the newborn coverage mandate regulates when newborns must be covered. The mandate regarding care delivered in veterans' homes and mobile field hospitals might be characterized as delivery methods. Like the telemedicine example HHS has provided, these laws do not mandate any particular care but rather the method by which the care is delivered to the patient. In the case of telemedicine, the care is delivered via an Internet connection, in the case of the Connecticut mandates, the care is delivered in a mobile field hospital and in a veterans' home. Alternatively, these last two mandates may be characterized as provider mandates.

The other Connecticut health benefit mandates in table V.21 are more difficult to characterize. The rehabilitative services mandate may be excluded from CCIIO's list because it does not actually mandate the provision of rehabilitative coverage, but rather requires only that carriers offer a group hospital or medical service plan or contract with such coverage. The maternity care mandate regulates when carriers' responsibility to cover certain costs related to maternity care ceases in the event that the policy is terminated. The mandate prohibiting denial of coverage based on consumption of alcohol or drugs might be described as an anti-discriminatory provision. The mandate requiring coverage for certain drugs that carriers have removed from their formulary does not require coverage of any particular drug, but rather regulates carriers' use of a particular prescription drug cost-containment technique.

In a few examples, it is unclear why some mandates do not appear on CCIIO's list but other, seemingly similar, mandates do. The chiropractor mandate appears to require the coverage of chiropractic services that are not otherwise mandated by state law. This mandate, then, may function similarly to the pain management mandate, which requires coverage of both certain providers and certain services.[286] The chiropractic services mandate is not on CCIIO's list of Connecticut-required benefits, though the pain management mandate is. Connecticut's mail order pharmacies mandate is included on CCIIO's list of Connecticut-required benefits. This mandate prohibits carriers from requiring insureds to use mail order pharmacies to secure medications in order for the prescriptions to be covered. It appears to function similarly to the removed prescription drug mandate mentioned above. Such ambiguities in what is and is not a state-required benefit may become more important in the future when Connecticut must determine whether a proposed health insurance law will trigger the cost-defray liability.

Amendments and enactments post-December 31, 2011

Twelve of Connecticut's state-required benefits, as recognized by CCIIO, have been amended in some manner since December 31, 2011. Many of these amendments have been technical in nature. Seven of the state-required benefits have received non-technical amendments. None of these, however, appear to mandate coverage of new care, treatment, or services and so are not likely to trigger cost-defray liability.

One set of amendments does not appear to require any changes to coverage at all, but rather a continuation of existing coverage. The DSM 5 revised the diagnosis of autism from what it had been in the prior edition. In response, Connecticut's General Assembly amended the mental health, autism and birth-to-three mandates to ensure that children diagnosed with autism spectrum disorder before the release of the DMS 5 continue to receive insurance coverage at a level at least as comprehensive as what they had been receiving.

Amendments to three state provisions appear similar to HHS's examples of laws that do not constitute state-required benefits. An amendment to the pain management services mandate added a provider type, physiatrists, to the list of covered providers. Two of Connecticut's preventive services mandates, colorectal cancer screening and breast cancer screening, were subject to cost-sharing amendments. The colorectal screening mandate was amended to prohibit the charge of deductibles in some circumstances, and the breast cancer screening mandate was amended to limit the charge of co-pays to $20 for breast cancer screening by ultrasound.

Amendments to three other Connecticut-required benefits do not as clearly fit any of the examples provided by HHS of laws that are not state-required benefits. Nevertheless, these amendments do not appear to require coverage of new care, treatment, or services, and, therefore, are unlikely to lead to cost-defray liability. The birth-to-three mandate was amended to clarify that carriers may not take certain adverse actions against an insured on the basis that the insured claimed benefits under the provision. Specifically listed sources of professional guidelines were eliminated from the colorectal cancer screening and breast cancer screening mandates. Finally, as of January 1, 2015, carriers are prohibited from employing the prescription drug cost containment technique of step therapy for more than 60 days and must allow a provider the means of requesting earlier termination of step therapy when medically necessary.

[286] CGS § 38a-492i; § 38a-518i.

Table V.21 *State provisions amended after December 31, 2011*

State provision	Public Act	Summary of amendments directly affecting benefits
Mental or nervous conditions		
CGS § 38a-488a; § 38a-514	13-84, s. 3, 4	An insured diagnosed with autism spectrum disorder before the release of the DSM 5 shall be covered pursuant to §§ 38a-488b (individual), 38a-514b (group).
Autism spectrum disorder therapies		
CGS § 38a-488b; § 38a-514b	13-84, s. 1, 2	Any insured diagnosed with autism spectrum disorder prior to the release of DSM 5 shall be covered at least at the same benefit levels covered before the release of DSM 5.
Birth-to-three		
CGS § 38a-490a; § 38a-516a	12-44, s. 1, 2	Prohibits carriers from certain actions that are adverse to the insured that are the result of the insured claiming birth-to-three related coverage.
	13-84, s. 5, 6	Coverage for children diagnosed with autism spectrum disorder before the release of the DSM 5 must be provided at least at the same levels before the release of the DSM 5.
Pain management		
CGS § 38a-492i; § 38a-518i	12-197, s. 20, 21	Adds "physiatrist" to list of "pain management specialist."
Colorectal cancer screening		
CGS § 38a-492k; § 38a-518k	12-61, s. 1, 2	Eliminates American College of Gastroenterology and the American College of Radiology from sources of screening guidance.
	12-190, s. 1, 2	Prohibits deductibles for screening colonoscopy or a screening sigmoidoscopy.
Breast cancer screening		
CGS § 38a-503; § 38a-530	12-150, s. 1, 2	Removes American College of Radiology from list of guideline sources for MRI screening coverage.
	14-97, s. 1, 2	Limits co-payments for ultrasound to $20.
Mail order pharmacies and step therapy		
CGS § 38a-510; § 38a-544	14-118, s. 1, 2	Defines step therapy and limits carriers from requiring it beyond 60 days. Provides means for providers to request discontinuation of step therapy before expiration of 60 days.

There has been a new statutory provision enacted after December 31, 2011 that may meet Connecticut's definition of health benefit mandate. It is a cost-sharing mandate limiting the types of co-payments carriers may require of insureds for physical therapy sessions and occupational therapy sessions. This provision is similar to the imaging services co-payment mandate previously reviewed by CPHHP. It does not appear to satisfy the federal definition of state-required benefit, and, therefore, is unlikely to lead to cost-defray liability.

Summary:
Connecticut is not likely to have incurred any cost-defray liability for state-required benefits in excess of EHB for plan year 2014 or 2015. Although Connecticut did amend some mandates after 2011, none of these amendments appear to meet the HHS definition of "state-required benefits" as set forth in the comments on the final rule for additional required benefits.[287] HHS affirmed that it interprets "state-required benefits" to include the care, treatment and services that an issuer must provide to its enrollees. Other state laws that do not relate to specific benefits, including those relating to providers and benefit delivery method, are not addressed in (45 CFR) §155.170. It should be noted that HHS has delegated to the Exchanges the authority to determine which state-required benefits are in excess of EHB.

If HHS keeps in place the current definition of EHB, the state will only incur cost-defray liability for year 2016 if it enacts a provision that requires QHPs to cover care, treatment or services that are not currently part of Connecticut's EHB package or are otherwise identified as EHB by HHS. If HHS decides to change the current definition of EHB in the future, however, potential cost-defray liability for existing law would have to be re-examined.

[287] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12838 (Feb 25, 2013).

VI. Medical Necessity Review

This review identified those mandates for which previous reviews noted that, for the service described in the mandate, medical profession debate existed, supporting evidence was weak or mixed, or professional guideline(s) favored the benefit without high-levels of supporting evidence. Mandates were also considered for this review if the mandate addressed a preventive health screening or if the statutory language had a high level of specificity for who would receive the benefit and how. The preventive health screening benefits were included because screening techniques and protocols tend to change over time. Similarly, statutes with a high level of specificity were included because they might become outdated more quickly than broadly worded mandates, or mandates tied to relevant professional guidelines.

Using this approach, the following 12 mandated benefits were identified for further review:

1) Breast cancer screening (mammography, breast ultrasound, MRI)
2) Colorectal cancer screening
3) Prostate cancer screening
4) Preventive pediatric care
5) Blood lead screening
6) Lyme disease treatment
7) Autism spectrum disorder therapies
8) Maternity minimum stay
9) Chiropractic services
10) Occupational therapy
11) Birth-to-three
12) Diabetes self-management training

Of the twelve benefits identified, eight benefits were examined for updated guidelines or evidence (shown in Table VI.1.) These included five preventive health screening mandates, Lyme disease treatment, autism spectrum disorder (ASD), and diabetes self-management training. In the prior CPHHP reviews, debate among the medical profession or a lack of high level scientific evidence was indicated for five of these benefits: blood lead screening and risk assessment, breast cancer screening, Lyme disease treatment, and autism spectrum disorder, plus maternity minimum stay. Maternity minimum stay was not examined for updated evidence because it is unlikely there would be a relevant change in provider opinion regarding appropriate minimum and optimal length of stay than what was previously reported.

For three other mandates, there was mixed evidence: chiropractic services, occupational therapy and birth-to-three services. The medical literature, however, showed these treatments to be effective for certain populations, with certain conditions or a varied duration of positive effect. In practice, these treatments are commonly prescribed for a variety of populations and conditions. Since these benefits were considered effective in some cases during the previous review, they were not examined further for updated evidence.

Table. VI.1

Mandate	Conflicting findings in prior review	Recent evidence and other considerations
Colorectal cancer screening § 38a-518k, § 38a-492k Enacted 2001	No.	Some differences exist between 2014 American Cancer Society[287] and 2008 U.S. Preventive Services Task Force (USPSTF) recommendations.[288] At the time of this review, an update is in progress for the USPSTF recommendations.
Prostate cancer screening and treatment § 38a-518g, § 38a-492g Screening Enacted 2000 Treatment Enacted 2012	Yes. Differences in age and frequency of screenings existed when comparing the USPSTF (2008),[289] American Cancer Society (2009),[290] and American Urology Association (2009).[291]	1) Significant change in screening standards since initial report. As of May 2012, USPSTF recommends against using prostate specific antigen (PSA) screening.[292] American Urology Association (2013) increased age to 54 years but allows earlier screenings for men at higher risk.[293] 2) Language of statute, as of this review, is somewhat inconsistent with American Cancer Society[294] and American Urology Association. As noted above, the statute does not follow USPSTF 2012 recommendations against PSA.
Preventive pediatric care § 38a-535 Enacted 1989	No. The 2010 review referenced the Bright Futures periodicity table published by the American Academy of Pediatrics.	The Bright Futures periodicity table is updated every year.

[288] American Cancer Society. American Cancer Society recommendations for colorectal cancer early detection. Last medical review 10/15/2014. Last revised: 10/29/2014. Accessed 1/5/2015 from: http://www.cancer.org/cancer/colonandrectumcancer/moreinformation/colonandrectumcancerearlydetection/colorectal-cancer-early-detection-acs-recommendations.

[289] U.S. Preventive Services Task Force. Final Recommendation Statement: Colorectal Cancer: Screening. Current as of: October 2008. Accessed 1/5/2015 from: http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening.

[290] U.S. Preventive Services Task Force. 2008. Screening for Prostate Cancer: U.S. Preventive Services Task Force Recommendation Statement. *Ann. Int. Med.* 149(3);185.

[291] Smith R, Cokkinides V, Brawley O. 2009. Cancer screening in the United States, 2009, A review of current American Cancer Society guidelines and issues in cancer screening. *CA Cancer J Clin* 59(1);27-41.

[292] American Urological Association. 2009. AUA New Guidelines on Prostate Cancer Screening. Accessed 1/13/2015 from: http://www.psa-rising.com/mednews/component/content/article/38-screening/78-aua-new-guidelines-on-prca-screening.

[293] USPSTF Prostate Cancer: Screening. Final Recommendation. Release Date: May 2012. First published Annals of Internal Medicine (*Ann Intern Med* 2012; 22 May).

[294] Ballentine Carter H, Albertsen P, Barry M *et al.* Early Detection of Prostate Cancer: AUA Guideline. Approved by the AUA Board of Directors April 2013. American Urology Association (AUA) Guideline.

[295] Wolf, A. M. D., Wender, R. C., Etzioni, R. B., Thompson, I. M., D'Amico, A. V., Volk, R. J., Brooks, D. D., Dash, C., Guessous, I., Andrews, K., DeSantis, C. and Smith, R. A. (2010), American Cancer Society Guideline for the Early Detection of Prostate Cancer: Update 2010. *CA: A Cancer Journal for Clinicians,* 60: 70–98

Table. VI.1

Mandate	Conflicting findings in prior review	Recent evidence and other considerations
Blood lead screening § 38a-535, § 38a-490d Enacted 2009	Yes. The prior review notes, "The USPSTF, CDC, AAP, American College of Preventive Medicine, and the Medicaid EPSDT Program put forth varying recommendations or guidelines for blood lead risk assessment and screening for children."[296] Debate existed over who should be screened. The USPSTF guidance (2006) found insufficient evidence to recommend for or against routine screening in asymptomatic children who are at increased risk and a "D" grade was given for those at average risk.	Since the last review, USPSTF has not issued an update. The CDC Advisory Committee on Childhood Lead Poisoning, however, reconvened and updated recommendations in 2012.[297] This is the source referenced in the AAP/ Bright Futures periodicity schedule. Connecticut's Childhood Lead Poisoning Prevention Screening Advisory Committee reconvened and issued a revised "Requirements and Guidance for Childhood Lead Screening by Health Care Professionals in Connecticut"[298] in 2013. CGS §19a-111g was amended in 2014 to add a requirement for patient education, "and to change the wording of the requirement from "screening" to "testing."" (The patient education requirement is consistent with the updated CDC Advisory Committee recommendations). It may be worth exploring if the statutory language for 19a-111g is broad enough to encompass any changes that might occur in recommendations and what would happen if at some point the Connecticut advisory committee guidance diverges from the schedule described in 19a-111g.

[296] University of Connecticut, Center for Public Health and Health Policy, Connecticut Mandated Health Insurance Benefits Reviews 2010, Volume II Chapter 8: "Blood Lead Screening and Risk Assessment," pg. 145.

[297] Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention. Report of the Advisory Committee on Childhood Lead Poisoning Prevention of the Centers for Disease Control and Prevention. January 4, 2012. Accessed 1/5/2015 from: http://www.cdc.gov/nceh/lead/acclpp/final_document_030712.pdf. CDC responses to the ACLPP recommendations can be found: http://www.cdc.gov/nceh/lead/acclpp/cdc_response_lead_exposure_recs.pdf.

[298] Connecticut Department of Public Health. Requirements and guidance for childhood lead screening by health care professionals in Connecticut. Lead Poisoning Prevention and Control Program (revised April 2013), available at: http://www.sde.ct.gov/sde/lib/sde/PDF/publications/lead_poison/appendixf.pdf (accessed January 22, 2015).

Table. VI.1

Mandate	Conflicting findings in prior review	Recent evidence and other considerations
Breast cancer screening; § 38a-530, § 38a-503; Mammography: Enacted 1988 Breast ultrasound: Enacted 2005 MRI: Enacted 2011	Yes. "The USPSTF currently [December 2009][299] recommends against routine mammography for women under age 50 who are not at increased risk for breast cancer…and recommends biennial screening mammography for women 50-74 years of age."[300] USPSTF differed from American Cancer Society (ACS),[301, 302] and American College of Radiology (ACR).[303]	This Connecticut statute is, for the most part, not tied to prevailing professional standards. The statute does not tie age of baseline mammogram or age and frequency of mammogram to professional guidelines. Over time, criteria specified by statute may not keep pace with prevailing medical recommendations. At the time of this review, current statutory language for mammograms and ultrasound use is similar to the ACS. Connecticut's supplemental screening benefits are not methods recommended by USPSTF (2009)[304] but receive some support from ACS and ACR as an adjunct to mammograms. Use of MRI is tied to American Cancer Society recommendations.[305]
Diabetes Self-Management Training § 38a-518e, § 38a-492e Enacted 1999	No. Statute states diabetes self-management education (DSME) which was reflected in American Diabetes Association (ADA) DSME guidelines as reviewed in 2010.	• ADA guidelines changed from National Standards for Diabetes Self-Management Education to the National Standards for Diabetes Self-Management Education and Support.[306] The newer Standards (2014) added diabetes self-management "support" and applies to both diabetes and pre-diabetes. • This mandate is very specific as to who receives benefits and how many hours are covered. It is unclear if the hour limits specified in the statute are clinically significant for "dosage" of DSME. Such limits are not described in existing guidelines.

[299] U.S. Preventive Services Task Force. Screening for breast cancer: U.S. Preventive Services Task Force Recommendation Statement. *Ann Intern Med* 2009;151:716-726.

[300] University of Connecticut, Center for Public Health and Health Policy, Connecticut Mandated Health Insurance Benefits Reviews 2010, Volume II Chapter 1: "Mammography and Breast Ultrasound," pg. 11.

[301] Smith, Cokkinides and Brawley. 2009. Cancer Screening in the United States, 2009: a review of current American Cancer Society guidelines and issues in cancer screening.

[302] Saslow *et al.* 2007. American Cancer Society Guidelines for Breast Screening with MRI as an Adjunct to Mammography, *CA Cancer J Clin* 2007;57:75–89

[303] ACR. 2008. ACR Practice Guideline for the Performance of Contrast-Enhanced Magnetic Resonance Imaging (MRI) of the Breast.

[304] U.S. Preventive Services Task Force. Screening for breast cancer: U.S. Preventive Services Task Force Recommendation Statement. *Ann Intern Med* 2009;151:716-726.

[305] American Cancer Society. American Cancer Society recommendations for early breast cancer detection in women without breast symptoms. Last medical review 9/10/2014. Last revised: 9/10/2014. Accessed 1/5/2015 from: http://www.cancer.org/cancer/breastcancer/moreinformation/breastcancerearlydetection/breast-cancer-early-detection-acs-recs

[306] Haas L, Maryniuk M, Beck J *et al.* 2014. National Standards for Diabetes Self-Management Education and Support. Diabetes Care 37 (Supp 1). Accessed 1/5/2015 from: http://care.diabetesjournals.org/content/37/Supplement_1/S144.full

Table. VI.1

Mandate	Conflicting findings in prior review	Recent evidence and other considerations
Lyme Disease Treatments § 38a-518h; § 38a-492h; Enacted 1999	Yes. Lyme treatment was a subject of medical debate when previously reviewed.	This remains a subject of medical debate. As stated in the 2010 report, "From the perspective of managed care, Lyme treatment is contentious in two areas (1) patients without a clear diagnosis, and (2) patients with persistent symptoms and without positive biological tests."[307] "The Infectious Disease Society of American (IDSA) released treatment guidelines that preclude long-term antibiotic therapy. Community-based physicians and Lyme advocates contend these guidelines do not provide for adequate antibiotic therapy. Connecticut's mandate walks the fine line between these two groups. Connecticut's mandate allows for up to 30 days of IV antibiotics and 60 days of oral antibiotics. Any antibiotic therapy beyond this period needs to be prescribed by a board certified specialist."[308] The Connecticut mandate is more similar to 2014 guidelines from the International Lyme and Associated Diseases Society (ILADS),[309] which focuses on "advancing the standard of care for Lyme and its associated diseases." ILADS values promoting options and informed choice with recommendations in favor of treatment even when the evidence is rated "low" or "very low" and places an emphasis on clinicians using their own judgment.[310]
Autism spectrum disorder therapies § 38a-514b; Enacted 2009; Substantial changes Enacted 2010 *Note:* Individual only coverage exists for a less comprehensive set of benefits per § 38a-488b, enacted 2009.	Somewhat. Professional guidelines tend to recommend use of treatment approaches such as occupational therapy or behavior therapy even in the absence of a strong evidence base specific to treating autism spectrum disorder.	American Academy of Pediatrics (AAP) published an Autism Toolkit for Clinicians (2012).[311]

[307] University of Connecticut, Center for Public Health and Health Policy, Connecticut Mandated Health Insurance Benefits Reviews 2010, Volume I, Chapter 9: "Lyme Disease Treatments," pg. 156.

[308] University of Connecticut, Center for Public Health and Health Policy, Connecticut Mandated Health Insurance Benefits Reviews 2010, Volume I, Chapter 9: "Lyme Disease Treatments," pg. 156.

[309] Haas L, Maryniuk M, Beck J *et al.* 2014. National Standards for Diabetes Self-Management Education and Support. Diabetes Care 37 (Supp 1). Accessed 1/5/2015 from: http://care.diabetesjournals.org/content/37/Supplement_1/S144.full

[310] Infectious Disease Society of America. Final Report of the Lyme Disease Review Panel. http://www.idsociety.org/Lyme_Final_Report/

[311] American Academy of Pediatrics. Care for children with autism spectrum disorders: A resource toolkit for clinicians (no date), http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Pages/Caring-for-Children-with-Autism-Spectrum-Disorders-A-Resource-Toolkit-for-Clinicians.aspx

In addition to reviewing changes in evidence, mandates with limits to services or dollar values were also reviewed. Those that may no longer be practically significant are shown in Table VI.2. It should be noted that this table does not address the effect of the ACA's rules regarding dollar limits and their potential interaction with Connecticut's mandated benefits, which is discussed in Section V.

Table VI.2 *Mandates with dollar limits that may be outdated*

Mandate	Dollar Limits
Hearing Aids for Children Twelve and Under § 38a-516b § 38a-490b Enacted 2001	Plans can set a limit of no less than $1000 within a 24 month period. This limit was set 14 years ago and may be outdated.
Home Health Care § 38a-520 § 38a-493 Enacted 1975	Minimum coverage threshold for medical social services of $200 was established in 1975 and has not been updated since then.
Accidental Ingestion of Controlled Drug § 38a-518 § 38a-492 Enacted 1975	$500 outpatient benefit has not been updated since its enactment in 1975.
Tumors and Leukemia § 38a-542 § 38a-504 Enacted 1979	Some of the dollar thresholds have not been updated since their enactment and may be outdated. Most insurers reported not limiting benefits to these amounts.

VII. Conclusion

This report reviews all of Connecticut's mandated health insurance benefits, provides updated cost projections, and crosswalks the mandates to the Essential Health Benefits provisions of the federal Affordable Care Act and other federal laws that are applicable to health insurance benefits. CPHHP identified 46 existing mandated benefits, of which 27 have been amended since they were initially reviewed. Twelve of these were amended substantively and fifteen received technical amendments only. Three additional mandates were found that have never been reviewed by CPHHP.

OptumInsight, Inc. (Optum) was contracted by the Connecticut Insurance Department to update the cost projections for those mandates that were previously reviewed. This report includes Optum's cost projections and a copy of Optum's report is attached to this report as an appendix.

Twenty-two mandates have parallel federal laws on the same subject matter. These federal rules affect preventive health services, prescription drugs, mental health parity, routine patient care costs during clinical trials, direct access to obstetricians and gynecologists, mothers' and newborns' minimum post-delivery hospital stays, enrollment of newborns, and post-mastectomy reconstructive surgery. In addition, federal rules regarding age discrimination, annual and lifetime benefit limits and cost-sharing limits are applicable to Connecticut mandated benefits. The report analyzes these federal laws and compares them to the Connecticut mandate requirements.

The report lists the Connecticut mandates and identifies the Essential Health Benefit categories that are applicable to each. In many instances, more than one EHB category applies, since mandates often cover several types of services. CPHHP also reviewed the ACA and HHS rules on state-required benefits in excess of EHB, and determined that no current mandates are likely to be found in excess of EHB for the 2014 and 2015 plan years.

Finally, the report reviews twelve mandates for current medical necessity research. Mandates were chosen for medical necessity review if the prior review indicated a disagreement among the medical professions as to appropriate diagnosis or standards of care, or where supporting evidence for medical necessity was weak or mixed. Additionally, mandates that addressed preventive services or that were highly specific as to who would receive the benefit or how a service was to be provided were also reviewed, as standards of care tend to change over time.

CPHHP thanks the Connecticut Insurance Department for the opportunity to undertake this important research.

Appendix I. Request letter from Insurance and Real Estate Committee

State of Connecticut
GENERAL ASSEMBLY

Senator Joseph J. Crisco, Jr.
CO-CHAIRMAN

Senator Joan V. Hartley, *Vice Chair*
Senator Kevin C. Kelly, *Ranking Member*

Representative Robert W. Megna
CO-CHAIRMAN

Representative Christopher A. Wright, *Vice Chair*
Representative Robert C. Sampson, *Ranking Member*

INSURANCE AND REAL ESTATE COMMITTEE

July 30, 2014

Thomas B. Leonardi, Commissioner
State of Connecticut Insurance Department
P O Box 816
Hartford, CT 06142-0816

Dear Commissioner Leonardi:

Pursuant to Conn. Gen. Stat. §38a-21, we respectfully request that the Insurance Department, through its statutory designees, conduct a review of all existing mandated health benefits, as defined by Conn. Gen. Stat. §38a-21(a)(2). We are aware that a complete cost-benefit analysis review of existing mandates was undertaken in 2010 and believe this information will be foundational to the current request.

Current Essential Health Benefits ("EHB") are based on state identified benchmark plans as identified and selected in 2012 and applied to 2014 and 2015 plans. It is anticipated that the US Health And Human Services Department ("HHS") will review EHBs in 2014 and make a determination as to whether EHBs for 2016 plans, filed with regulators for approval in first quarter 2015, will continue to be set by the states or by the federal government. Therefore, we need to review the mandates in anticipation of potential changes by HHS to EHBs.

Specifically, we request the following:

- Update all the prior reviews to 2016 cost analysis.
- Create a crosswalk between all Connecticut mandated health benefits and the current Connecticut benchmark essential health benefits
  - Categorize each mandate within its respective EHB category
  - Identify any changes to the mandate since the 2010 review; if the mandate was not part of the 2010 or a subsequent review , it should undergo the cost-benefit analysis
  - Crosswalk the mandate to mandates in the Affordable Care Act to identify conflicts, redundancies etc.
  - Determine if any state mandates enacted or revised subsequent to December 31, 2011 represent changes that will become the financial obligation of the state rather than the federal government through its subsidy or the individual for non-subsidized policyholders purchased through the Exchange.
- Using the 2010 cost benefit analysis and subsequent reviews as applicable, review the existing mandates and any mandates enacted since that review was conducted, to determine if any of the existing mandates should be repealed because they are no longer cost effective or medically necessary.

Because of the expected scope and scale of this request which exceeds the usual cost-benefit analysis review provided for in Conn. Gen. Stat. §38a-21, we also request that our delivery date be extended to February 1, 2015 rather than the statutory date of January 1, 2015.

Thank you for your attention to our request. We look forward to hearing from you and your designees.

Best Regards,

Senator Joseph Crisco, Jr.
Co-Chair Insurance & Real Estate Committee

Representative Robert W. Megna
Co-Chair Insurance & Real Estate Committee

Room 2800 L.O.B., 300 Capitol Avenue, Hartford, CT 06106-1591 ❖ Phone: (860) 240-0510 ❖ FAX: (860) 240-0027

Appendix II. Miscellaneous Tables

Table 1. List of Connecticut Health Benefit Mandates			
Connecticut Health Benefit Mandate	**Individual**	**Group**	**CPHHP Review**
Psychotropic drug availability	38a-476b	38a-476b	2010.III.1
Experimental treatments	38a-483c	38a-513b	2010.IV.1
Mental or nervous conditions	38a-488a	38a-514	2010.III.2
Autism spectrum disorder therapies	38a-488b	38a-514b	2010.II.6 2012.1
Coverage of newborns	*38a-490*	*38a-516*	*2010.II.7*
Birth-to-three	38a-490a	38a-516a	2010.I.8
Hearing aids for children twelve and under	38a-490b	38a-516b	2010.I.4
Craniofacial disorders	38a-490c	38a-516c	2010.I.5
Blood lead screening and risk assessment	38a-490d	38a-535	2010.II.8
Services performed by a dentist	*38a-491*	*38a-517*	*
Inpatient, outpatient, and one-day dental services	38a-491a	38a-517a	2010.I.6
Accidental ingestion of controlled drugs	38a-492	38a-518	2010.III.3
Hypodermic needles and syringes	38a-492a	38a-518a	2010.IV.4
Off-label use of certain drugs	38a-492b	38a-518b	2010.IV.2
Certain specialized foods	38a-492c	38a-518c	2010.II.9
Diabetes testing and treatment	38a-492d	38a-518d	2010.I.7
Diabetic self-management training	38a-492e	38a-518e	2010.I.1
Prescription drugs removed from formulary	*38a-492f*	*38a-518f*	*2010.IV.5*
Prostate cancer screening and treatment	38a-492g	38a-518g	2010.I.2
Lyme disease treatments	38a-492h	38a-518h	2010.I.9
Pain management	38a-492i	38a-518i	2010.IV.12 2012.4
Ostomy-related supplies	38a-492j	38a-518j	2010.I.3
Colorectal cancer screening	38a-492k	38a-518k	2009.6 2010.I.10
Neuropsychological testing for children diagnosed with cancer	38a-492l	38a-516d	2010.II.10
Wound care for epidermolysis bullosa	38a-492n	38a-518m	*
Bone marrow testing	38a-492o	38a-518o	2009.5
Home health care	38a-493	38a-520	2010.IV.6
Occupational therapy	38a-496	38a-524	2010.III.6
Ambulance services	38a-498	38a-525	2010.IV.7
Mobile field hospital	*38a-498b*	*38a-525b*	*2010.IV.11*

Italicized font indicates the mandate is not a state-required benefit.
*These statutory sections have not been reviewed by CPHHP.

Table 1. List of Connecticut Health Benefit Mandates

Connecticut Health Benefit Mandate	Individual	Group	CPHHP Review
Elevated blood alcohol content	*38a-498c*	*38a-525c*	*2010.III.4*
Services of physician assistants and certain nurses	*38a-499*	*38a-526*	*2010.III.7*
Services provided by the Veterans' Home	*38a-502*	*38a-529*	*2010.III.8*
Breast cancer screening	38a-503	38a-530	2010.II.1 2011.2
Direct access to obstetrician-gynecologists	*38a-503b*	*38a-530b*	*2010.III.9*
Maternity minimum stay	38a-503c	38a-530c	2010.II.2
Mastectomy or lymph node dissection minimum stay	38a-503d	38a-530d	2010.II.3
Prescription contraceptives	38a-503e	38a-530e	2010.II.4
Tumors and leukemia	38a-504	38a-542	2010.I.11
Clinical trials	38a-504a *et seq.*	38a-542a *et seq.*	2010.IV.3
Chiropractic services	*38a-507*	*38a-534*	*2010.III.10*
Infertility diagnosis and treatment	38a-509	38a-536	2010.II.5
Mail order pharmacies and step therapy	38a-510	38a-544	2010.IV.8
Co-payments regarding in-network imaging services	*38a-511*	*38a-550*	*2010.IV.9*
Co-payments for physical therapy and occupational therapy	*38a-511a*	*38a-550a*	*
Rehabilitative services (mandatory offer)	*(group only)*	*38a-523*	*2010.IV.10*
Medical complications of alcoholism	(group only)	38a-533	2010.III.5
Preventive pediatric care	(group only)	38a-535	2010.II.11
Maternity benefits and pregnancy care following policy termination	*(group only)*	*38a-547*	*2010.IV.13*

Italicized font indicates the mandate is not a state-required benefit.
*These statutory sections have not been reviewed by CPHHP.

Table 2. Enactments and Select Amendments

Connecticut Health Benefit Mandate	Individual	Group	Original enactment (before Dec. 31, 2011)	Amended post-CPHHP review, but before Dec. 31, 2011	Enacted or amended after Dec. 31, 2011
Psychotropic drug availability	38a-476b	38a-476b	PA 01-171, s. 17		
Experimental treatments	38a-483c	38a-513b	PA 99-284, s. 15, 16, 60	PA 11-58, s. 81, 82	PA 12-145, s. 43, 44
Mental or nervous conditions	38a-488a	38a-514	1971, PA 238, s. 1 (group); June 18 Sp. Sess. PA 97-8 , s. 63, 88 (individual)		PA 12-145, s. 19, 45, 46; PA 13-84, s. 3, 4; PA 13-139, s. 33, 34; PA 14-235, s. 57, 58
Autism spectrum disorder therapies	38a-488b	38a-514b	PA 08-132, s. 1, 2	PA 11-4, s. 6, 7	PA 12-145, s. 20; PA 13-84, s. 1, 2
Coverage of newborns	38a-490	38a-516	PA 74-6, s. 1-4 (individual); PA 90-243, s. 100 (group)	PA 11-19, s. 35, 36; PA 11-171, s. 3, 4	PA 12-145, s. 12, 13
Birth-to-three	38a-490a	38a-516a	PA 96-185, s. 6, 7, 16	Sept. Sp. Sess. PA 09-3, s. 45, 46; PA 11-44, s. 147, 148	PA 12-44, s. 1, 2; PA 13-84, s. 5, 6; PA 14-235, s. 18, 19
Hearing aids for children twelve and under	38a-490b	38a-516b	PA 01-171, s. 15, 16		PA 12-145, s. 47, 48
Craniofacial disorders	38a-490c	38a-516c	PA 03-37, s. 1, 2		
Blood lead screening and risk assessment	38a-490d	38a-535	PA 89-101 (group); June Sp. Sess. PA 07-2, s. 51 (individual)		
Services performed by a dentist*	38a-491	38a-517	PA 75-449 (individual); PA 90-243, s. 101 (group)		
Inpatient, outpatient, and one day dental services	38a-491a	38a-517a	PA 99-284, s. 40, 41, 60	PA 10-5, s. 20, 27	
Accidental ingestion of a controlled drugs	38a-492	38a-518	PA 75-512, s. 1, 2 (individual); PA 90-243, s. 102 (group)		
Hypodermic needles and syringes	38a-492a	38a-518a	PA 92-185, s. 4, 5, 6	PA 11-19, s. 37, 38	
Off-label use of certain drugs	38a-492b	38a-518b	PA 94-49, s. 1, 2	PA 11-19, s. 39, 40; PA 11-172, s. 15, 16	

* These statutory sections have not been reviewed by CPHHP.

Table 2. Enactments and Select Amendments					
Connecticut Health Benefit Mandate	Individual	Group	Original enactment (before Dec. 31, 2011)	Amended post-CPHHP review, but before Dec. 31, 2011	Enacted or amended after Dec. 31, 2011
Certain specialized foods	38a-492c	38a-518c	PA 97-167, s. 1, 2		PA 12-145, s. 54, 55
Diabetes testing and treatment	38a-492d	38a-518d	PA 97-268, s. 4, 5		
Diabetic self-management training	38a-492e	38a-518e	PA 99-284, s. 43, 44, 60		
Prescription drugs removed from formulary	38a-492f	38a-518f	PA 99-284, s. 37, 38, 60		PA 12-145, s. 56, 57
Prostate cancer screening and treatment	38a-492g	38a-518g	PA 99-284, s. 45, 46, 60		
Lyme disease treatments	38a-492h	38a-518h	PA 99-284, s. 47, 48, 60		
Pain management	38a-492i	38a-518i	PA 00-216, s. 18, 19, 28	PA 11-169, s. 1, 2	PA 12-197, s. 20, 21
Ostomy-related supplies	38a-492j	38a-518j	PA 00-63, s. 1, 2	PA 10-5, s. 21, 28; PA 11-204, s. 1, 2	
Colorectal cancer screening	38a-492k	38a-518k	PA 01-171, s. 20, 21	PA 11-83, s. 1, 2	PA 12-61, s. 1, 2; PA 12-190, s. 1, 2
Neuropsychological testing for children diagnosed with cancer	38a-492l	38a-516d	PA 06-131, s. 2, 3		
Wound care for epidermolysis bullosa*	38a-492n	38a-518m	PA 09-51, s. 1, 2		
Bone marrow testing	38a-492o	38a-518o	PA 11-88, s. 1, 2		
Home health care	38a-493	38a-520	PA 75-623, s. 1 (individual); PA 90-243, s. 104 (group)	PA 11-19, s. 41, 42, 43, 44	
Occupational therapy	38a-496	38a-524	PA 82-148 (individual); PA 90-243, s. 108 (group)	PA 11-19, s. 45, 46	
Ambulance services	38a-498	38a-525	PA 83-325 (individual); PA 90-243, s. 109 (group)		PA 12-145, s. 58, 59
Mobile field hospital	38a-498b	38a-525b	PA 05-280, s. 64, 65		PA 12-145, s. 49, 50

* These statutory sections have not been reviewed by CPHHP.

Table 2. Enactments and Select Amendments

Connecticut Health Benefit Mandate	Individual	Group	Original enactment (before Dec. 31, 2011)	Amended post-CPHHP review, but before Dec. 31, 2011	Enacted or amended after Dec. 31, 2011
Elevated blood alcohol content	38a-498c	38a-525c	PA 06-39, s. 1, 2		PA 12-145, s. 51, 52
Services of physician assistants and certain nurses	38a-499	38a-526	PA 84-231 (individual); PA 90-243, s. 110 (group)	PA 11-19, s. 47, 48	
Services provided by the Veterans' Home	38a-502	38a-529	PA 88-68 (individual); PA 90-243, s. 113 (group)		
Breast cancer screening	38a-503	38a-530	PA 88-124, s. 1 (individual); PA 90-243, s. 114 (group)		PA 12-150, s. 1, 2; PA 14-97, s. 1, 2
Direct access to obstetrician-gynecologists	38a-503b	38a-530b	PA 95-199, s. 1, 2	PA 10-32, s. 120, 121; PA 11-19, s. 49, 50	
Maternity minimum stay	38a-503c	38a-530c	PA 96-177, s. 1, 2, 6	PA 11-19, s. 51, 52	
Mastectomy or lymph node dissection minimum stay	38a-503d	38a-530d	PA 97-198, s. 1, 2, 5	PA 11-19, s. 8, 9	
Prescription contraceptives	38a-503e	38a-530e	PA 99-79, s. 1, 2	PA 11-19, s. 53, 54	
Tumors and leukemia	38a-504	38a-542	PA 79-327, s. 2 (individual); PA 90-243, s. 123 (group)	PA 10-5, s. 24, 31;PA 10-63, s. 1, 2; PA 11-19, s. 10, 11	
Clinical trials	38a-504a	38a-542a	PA 01-171, s. 1, 8, 25	PA 11-19, s. 57, 62; PA 11-172, s. 1, 8	
Clinical trials	38a-504b	38a-542b	PA 01-171, s. 2, 9, 25	PA 11-19, s. 58, 63; PA 11-172, s. 2, 9	
Clinical trials	38a-504c	38a-542c	PA 01-171, s. 3, 10, 25	PA 11-19, s. 59, 64; PA 11-172, s. 3, 10	
Clinical trials	38a-504d	38a-542d	PA 01-171, s. 4, 11, 25	PA 11-19, s. 60, 65; PA 11-172, s. 4, 11	
Clinical trials	38a-504e	38a-542e	PA 01-171, s. 5, 12, 25	PA 11-172, s. 5, 12	

* These statutory sections have not been reviewed by CPHHP.

Table 2. Enactments and Select Amendments					
Connecticut Health Benefit Mandate	**Individual**	**Group**	**Original enactment (before Dec. 31, 2011)**	**Amended post-CPHHP review, but before Dec. 31, 2011**	**Enacted or amended after Dec. 31, 2011**
Clinical trials	38a-504f	38a-542f	PA 01-171, s. 6, 13, 25	PA 11-19, s. 61, 66; PA 11-58, s. 83, 84; PA 11-172, s. 6, 13	PA 12-145, s. 21
Clinical trials	38a-504g	38a-542g	PA 01-171, s. 7, 14, 25	PA 11-172, s. 7, 14	PA 12-145, s. 16, 17
Chiropractic services	38a-507	38a-534	PA 89-112 (individual); PA 90-243, s. 177 (group)	PA 11-19, s. 55, 56	
Infertility diagnosis and treatment	38a-509	38a-536	PA 89-120 (group); PA 05-196, s. 1 (individual)		
Mail order pharmacies and step therapy	38a-510	38a-544	PA 89-374 (group); PA 05-233, s. 1 (individual)		PA 14-118, s. 1, 2
Co-payments regarding in-network imaging services	38a-511	38a-550	PA 06-180, s. 1, 2	PA 10-5, s. 25	
Co-payments for physical therapy and occupational therapy*	38-511a	38a-550a	PA 13-307, s. 1, 2		PA 14-97, s 3, 4
Rehabilitative services (mandatory offer)	(group only)	38a-523	PA 82-20, s. 1, 2		
Medical complications of alcoholism	(group only)	38a-533	PA 74-162, s. 1-6		
Preventive pediatric care	(group only)	38a-535	PA 89-101		
Maternity benefits and pregnancy care following policy termination	(group only)	38a-547	PA 90-302		

* These statutory sections have not been reviewed by CPHHP.

The mandates that have differences between the requirements for group and the requirements for individual coverage are listed in Table 3. Where the individual and group statutes have similar provisions with slight wording differences, the wording differences are highlighted with *italicized* text.

Table 3. CT Health Benefit Mandates: Instances of Language Variation Between the Statutes Governing Group and Individual Policies

Individual	Group
Mental or nervous conditions § 38a-488a; § 38a-514	
No parallel provisions	(j) A group health insurance policy may exclude the benefits required by this section if such benefits are included in a separate policy issued to the same group by an insurance company, health care center, hospital service corporation, medical service corporation or fraternal benefit society. Such separate policy, which shall include the benefits required by this section and the benefits required by section 38a-533, shall not be required to include any other benefits mandated by this title. (k) In the case of benefits based upon confinement in a residential treatment facility, such benefits shall be payable in situations in which the insured has a serious mental or nervous condition that substantially impairs the insured's thoughts, perception of reality, emotional process or judgment or grossly impairs the behavior of the insured, and, upon an assessment of the insured by a physician, psychiatrist, psychologist or clinical social worker, cannot appropriately, safely or effectively be treated in an acute care, partial hospitalization, intensive outpatient or outpatient setting. (l) The services rendered for which benefits are to be paid for confinement in a residential treatment facility shall be based on an individual treatment plan. For purposes of this section, the term "individual treatment plan" means a treatment plan prescribed by a physician with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Table 3. CT Health Benefit Mandates: Instances of Language Variation Between the Statutes Governing Group and Individual Policies	
Individual	Group
Autism spectrum disorder therapies § 38a-488b; § 38a-514b	
No parallel provision	(a) As used in this section: (1) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior. (2) "Autism services provider" means any person, entity or group that provides treatment for autism spectrum disorder pursuant to this section. (3) "Autism spectrum disorder" means a pervasive developmental disorder set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", including, but not limited to, Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified. (4) "Behavioral therapy" means any interactive behavioral therapies derived from evidence-based research, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with an autism spectrum disorder, that are: (A) Provided to children less than fifteen years of age; and (B) provided or supervised by (i) a behavior analyst who is certified by the Behavior Analyst Certification Board, (ii) a licensed physician, or (iii) a licensed psychologist. For the purposes of this subdivision, behavioral therapy is "supervised by" such behavior analyst, licensed physician or licensed psychologist when such supervision entails at least one hour of face-to-face supervision of the autism services provider by such behavior analyst, licensed physician or licensed psychologist for each ten hours of behavioral therapy provided by the supervised provider. (5) "Diagnosis" means the medically necessary assessment, evaluation or testing performed by a licensed physician, licensed psychologist or licensed clinical social worker to determine if an individual has an autism spectrum disorder.

Table 3. CT Health Benefit Mandates: Instances of Language Variation Between the Statutes Governing Group and Individual Policies

Individual	Group
Continued...Autism spectrum disorder therapies § 38a-488b; § 38a-514b	
(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 that is delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for *physical therapy, speech therapy and occupational therapy services* for the treatment of autism spectrum disorder, *as set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", to the extent such services are a covered benefit for other diseases and conditions under such policy*, except that coverage for an insured under such policy who has been diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" shall be provided in accordance with subsection (b) of this section.	(b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 that is delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for the diagnosis and treatment of autism spectrum disorder, except that coverage for an insured under such policy who has been diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" shall be provided in accordance with subsection (i) of this section. *For the purposes of this section and section 38a-513c, an autism spectrum disorder shall be considered an illness.*

Table 3. CT Health Benefit Mandates: Instances of Language Variation Between the Statutes Governing Group and Individual Policies	
Individual	Group
Continued...Autism spectrum disorder therapies § 38a-488b; § 38a-514b	
No parallel provision	(c) Such policy shall provide coverage for the following treatments, provided such treatments are (1) medically necessary, and (2) identified and ordered by a licensed physician, licensed psychologist or licensed clinical social worker for an insured who is diagnosed with an autism spectrum disorder, in accordance with a treatment plan developed by a licensed physician, licensed psychologist or licensed clinical social worker pursuant to a comprehensive evaluation or reevaluation of the insured: (A) Behavioral therapy; (B) Prescription drugs, to the extent prescription drugs are a covered benefit for other diseases and conditions under such policy, prescribed by a licensed physician, licensed physician assistant or advanced practice registered nurse for the treatment of symptoms and comorbidities of autism spectrum disorder; (C) Direct psychiatric or consultative services provided by a licensed psychiatrist; (D) Direct psychological or consultative services provided by a licensed psychologist; (E) Physical therapy provided by a licensed physical therapist; (F) Speech and language pathology services provided by a licensed speech and language pathologist; and (G) Occupational therapy provided by a licensed occupational therapist.
No parallel provision	(d) Such policy may limit the coverage for behavioral therapy to a yearly benefit of fifty thousand dollars for a child who is less than nine years of age, thirty-five thousand dollars for a child who is at least nine years of age and less than thirteen years of age and twenty-five thousand dollars for a child who is at least thirteen years of age and less than fifteen years of age.
No parallel provision	(e) Such policy shall not impose (1) any limits on the number of visits an insured may make to an autism services provider pursuant to a treatment plan on any basis other than a lack of medical necessity, or (2) a coinsurance, copayment, deductible or other out-of-pocket expense for such coverage that places a greater financial burden on an insured for access to the diagnosis and treatment of an autism spectrum disorder than for the diagnosis and treatment of any other medical, surgical or physical health condition under such policy.

Table 3. CT Health Benefit Mandates: Instances of Language Variation Between the Statutes Governing Group and Individual Policies

Individual	Group
*Continued...*Autism spectrum disorder therapies § 38a-488b; § 38a-514b	
No parallel provision	(f) (1) Except for treatments and services received by an insured in an inpatient setting, an insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society may review a treatment plan developed as set forth in subsection (c) of this section for such insured, in accordance with its utilization review requirements, not more than once every six months unless such insured's licensed physician, licensed psychologist or licensed clinical social worker agrees that a more frequent review is necessary or changes such insured's treatment plan. (2) For the purposes of this section, the results of a diagnosis shall be valid for a period of not less than twelve months, unless such insured's licensed physician, licensed psychologist or licensed clinical social worker determines a shorter period is appropriate or changes the results of such insured's diagnosis.
No parallel provision	(g) Coverage required under this section may be subject to the other general exclusions and limitations of the group health insurance policy, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and case management provisions, except that any utilization review shall be performed in accordance with subsection (f) of this section.
No parallel provision	(h) (1) Nothing in this section shall be construed to limit or affect (A) any other covered benefits available to an insured under (i) such group health insurance policy, (ii) section 38a-514, or (iii) section 38a-516a, (B) any obligation to provide services to an individual under an individualized education program pursuant to section 10-76d, or (C) any obligation imposed on a public school by the Individual With Disabilities Education Act, 20 USC 1400 et seq., as amended from time to time. (2) Nothing in this section shall be construed to require such group health insurance policy to provide reimbursement for special education and related services provided to an insured pursuant to section 10-76d, unless otherwise required by state or federal law.

Table 3. CT Health Benefit Mandates: Instances of Language Variation Between the Statutes Governing Group and Individual Policies

Individual	Group
*Continued...*Autism spectrum disorder therapies § 38a-488b; § 38a-514b	
(b) Each such policy shall maintain, for any insured diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders," *coverage for physical therapy, speech therapy and occupational therapy services* for the treatment of said disorder at the benefit levels, at a minimum, provided immediately preceding the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders."	(i) Each such group health insurance policy shall maintain, for any insured diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", coverage as *set forth in this section* for the treatment of said disorder at the benefit levels, at a minimum, provided immediately preceding the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders."
Birth-to-three § 38a-490a; § 38a-516a	
(c) Such policy shall provide a maximum benefit of six thousand four hundred dollars per child per year and an aggregate benefit of nineteen thousand two hundred dollars per child over the total three-year period.	(c) Such policy shall provide a maximum benefit of six thousand four hundred dollars per child per year and an aggregate benefit of nineteen thousand two hundred dollars per child over the total three-year period, *except that for a child with autism spectrum disorder, as defined in section 38a-514b, who is receiving early intervention services as defined in section 17a-248, the maximum benefit available through early intervention providers shall be fifty thousand dollars per child per year and an aggregate benefit of one hundred fifty thousand dollars per child over the total three-year period as provided for in section 38a-514b. Nothing in this section shall be construed to increase the amount of coverage required for autism spectrum disorder for any child beyond the amounts set forth in section 38a-514b. Any coverage provided for autism spectrum disorder through an individualized family service plan pursuant to section 17a-248e shall be credited toward the coverage amounts required under section 38a-514b.*

Table 3. CT Health Benefit Mandates: Instances of Language Variation Between the Statutes Governing Group and Individual Policies

Individual	Group
Tumors and Leukemia § 38a-504; § 38a-542	
(a) Each insurance company, hospital service corporation, medical service corporation, health care center or fraternal benefit society that delivers, issues for delivery, renews, amends or continues in this state individual health insurance policies providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469, shall provide coverage under such policies for *the surgical removal of tumors and treatment* of leukemia, including outpatient chemotherapy, reconstructive surgery, cost of any non-dental prosthesis including any maxillo-facial prosthesis used to replace anatomic structures	(a) Each insurance company, hospital service corporation, medical service corporation, health care center or fraternal benefit society that delivers, issues for delivery, renews, amends or continues in this state group health insurance policies providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 shall provide coverage under such policies for treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, cost of any nondental prosthesis, including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis, outpatient chemotherapy following surgical procedures in connection with the treatment of tumors, a wig if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy, *and costs of removal of any breast implant which was implanted on or before July 1, 1994, without regard to the purpose of such implantation, which removal is determined to be medically necessary.* Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies.
lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis, outpatient chemotherapy following surgical *procedure* in connection with the treatment of tumors, *and* a wig if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies.	

Table 3. CT Health Benefit Mandates: Instances of Language Variation Between the Statutes Governing Group and Individual Policies

Individual	Group
(b) Except as provided in subsection (c) of this section, the coverage required by subsection (a) of this section shall provide at least a yearly benefit of five hundred dollars for the surgical removal of tumors, five hundred dollars for reconstructive surgery, five hundred dollars for outpatient chemotherapy, three hundred fifty dollars for a wig and three hundred dollars for a nondental prosthesis, except that for purposes of the surgical removal of breasts due to tumors the yearly benefit for such prosthesis shall be at least three hundred dollars for each breast removed.	(b) Except as provided in subsection (c) of this section, the coverage required by subsection (a) of this section shall provide at least a yearly benefit of *one thousand dollars for the costs of removal of any breast implant*, five hundred dollars for the surgical removal of tumors, five hundred dollars for reconstructive surgery, five hundred dollars for outpatient chemotherapy, three hundred fifty dollars for a wig and three hundred dollars for a nondental prosthesis, except that for purposes of the surgical removal of breasts due to tumors the yearly benefit for such prosthesis shall be at least three hundred dollars for each breast removed.
Clinical Trials § 38a-504a *et seq.*; § 38a-542a *et seq.*	
(c) Notwithstanding the provision of subsection (a) of this section, routine patient care costs shall not include…(2) the cost of a non-health-care service that an insured person may be required to receive as a result of the treatment being provided for the purposes of the clinical trial…	(c) Notwithstanding the provision of subsection (a) of this section, routine patient care costs shall not include…(2) the cost of a non-health-care service that an insured person may be required to receive as a result of the treatment being provided for the purposes of the *cancer* clinical trial…

Table 3. CT Health Benefit Mandates: Instances of Language Variation Between the Statutes Governing Group and Individual Policies

Individual	Group
Chiropractic services § 38a-507; § 38a-534	
Each individual health insurance policy delivered, issued for delivery, renewed, amended or continued in this state…	Each group health insurance policy *providing coverage of the type specified in subdivisions (1), (2), (4), (6), and (11) of section 38a-469*, delivered , issued for delivery, renewed, amended or continued in this state…
Blood Lead Screening*/Preventive Pediatric Care § 38a-490d; § 38a-535	
No parallel provision	(a) For purposes of this section, "preventive pediatric care" means the periodic review of a child's physical and emotional health from birth through six years of age by or under the supervision of a physician. Such review shall include a medical history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards.
Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after January 1, 2009, shall provide coverage for blood lead screening and risk assessments ordered by a primary care provider pursuant to section 19a-111g.	(b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed *on or after October 1, 1989, or continued as defined in section 38a-531, on or after October 1, 1990, shall provide benefits for preventive pediatric care for any child covered by the policy or contract at approximately the following age intervals: Every two months from birth to six months of age, every three months from nine to eighteen months of age and annually from two through six years of age. Any such policy may provide that services rendered during a periodic review shall be covered to the extent that such services are provided by or under the supervision of a single physician during the course of one visit.* On *and* after January 1, 2009, *each such policy* shall *also* provide coverage for blood lead screening and risk assessments ordered by a primary care provider pursuant to section 19a-111g. *Such benefits shall be subject to any policy provisions which apply to other services covered by such policy.*

* The statutory section governing individual policies mandates the coverage of blood lead screening and risk assessment. The group policy section mandates coverage of this same benefit, blood lead screening and risk assessment, and, in addition, preventive pediatric services. For purposes of evaluating costs, these provisions are listed throughout this Review as two mandates, "blood lead screening and risk assessment" (individual and group policies) and "pediatric preventive care" (group policies only).

Table 4 follows the convention employed by the Connecticut General Assembly where text added to a statute is underlined, and text deleted from a statute is shown in [brackets]. To save space, only the text that was altered and the text surrounding it has been reproduced here. Where identical text was altered for the statutory section governing individual policies and the statutory section governing group policies, the text is only reproduced once in the table.

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.

Mandate	Public Act	Text
Experimental treatments		
§ 38a-483c § 38a-513b	11-58, s. 81, 82 (Effective July 1, 2011)	section [38a-226c] 58 of this act…section [38a-478n] 60 of this act. [(d) For the purposes of conducting an appeal pursuant to section 38a-478n on the grounds that an otherwise covered procedure, treatment or drug is experimental, the basis of such an appeal shall be the medical efficacy of such procedure, treatment or drug. The entity conducting the review may consider whether the procedure, treatment or drug (1) has been approved by the National Institute of Health or the American Medical Association, (2) is listed in the United States Pharmacopoeia Drug Information Guide for Health Care Professionals (USP-DI), the American Medical Association Drug Evaluations (AMA-DE), or the American Society of Hospital Pharmacists' American Hospital formulary Service Drug information (AHFS-DI), or (3) is currently in a phase III clinical trial of the federal Food and Drug Administration.]
	12-145, s. 43, 44 (Effective from passage; approved June 15, 2012)	[on or after January 1, 2000,]
Mental or nervous conditions		
§ 38a-488a § 38a-514	12-145, s. 19 (amending § 38a-514) (Effective from passage; approved June 15, 2012)	[must] shall
	12-145, s. 45, 46 (Effective from passage; approved June 15, 2012)	[on or after January 1, 2000,]
	13-84, s. 3 (amending CGS § 38a-488a) (Effective from passage; approved June 5, 2013)	, except that coverage for an insured under such policy who has been diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" shall be provided in accordance with subsection (b) of section 38a-488b, as amended by this act.

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.		
Mandate	**Public Act**	**Text**
	13-84, s. 4 (amending CGS § 38a-514) (Effective from passage; approved June 5, 2013)	, except that coverage for an insured under such policy who has been diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" shall be provided in accordance with subsection (i) of section 38a-514b, as amended by this act.
	13-139, s. 33, 34 (Effective October 1, 2013)	[mental retardation] intellectual disability,
	14-235, s. 57, 58 (Effective October 1, 2014)	"Mental or nervous conditions" does not include (1) intellectual [disability] disabilities, (2) specific learning disorders, (3) motor [skills] disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) [additional] other conditions that may be a focus of clinical attention
Autism spectrum disorder therapies		
§ 38a-488b § 38a-514b	11-4, s. 6 (amending CGS § 38a-488b) (Effective from passage; approved May 9, 2011)	autism spectrum [disorders] disorder,
	11-4, s. 7 (amending CGS § 38a-514b) (Effective from passage; approved May 9, 2011)	(a) As used in this section…(2) "Autism services provider" means any person, entity or group that provides treatment for autism spectrum [disorders] disorder pursuant to this section. (3) "Autism spectrum [disorders"] disorder" means [the] a pervasive developmental [disorders] disorder set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders"…. (b)…shall provide coverage for the diagnosis and treatment of autism spectrum [disorders] disorder. For the purposes of this section and section 38a-513c, an autism spectrum disorder shall be considered an illness. (c)…autism spectrum [disorders] disorder….
	12-145, s. 20 (amended CGS § 38a-514b) (Effective from passage; approved June 15, 2012)	age; [,]

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.

Mandate	Public Act	Text
	13-84, s. 1 (amending CGS § 38a-488b) (Effective from passage; approved June 5, 2013)	(a) …[on or after January 1, 2009,] …except that coverage for an insured under such policy who has been diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" shall be provided in accordance with subsection (b) of this section. (b) Each such policy shall maintain, for any insured diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", coverage for physical therapy, speech therapy and occupational therapy services for the treatment of said disorder at the benefit levels, at a minimum, provided immediately preceding the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".
	13-84, s. 2 (amending CGS § 38a-514b) (Effective from passage; approved June 5, 2013)	, except that coverage for an insured under such policy who has been diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" shall be provided in accordance with subsection (i) of this section…. (h) (1) Nothing in this section shall be construed to limit or affect (A) any other covered benefits available to an insured under (i) such group health insurance policy, (ii) section 38a-514, as amended by this act, or (iii) section 38a-516a, as amended by this act,… (i) Each such group health insurance policy shall maintain, for any insured diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", coverage as set forth in this section for the treatment of said disorder at the benefit levels, at a minimum, provided immediately preceding the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.		
Mandate	**Public Act**	**Text**
Coverage of newborns		
§ 38a-490 § 38a-516	11-19, s. 35 (amending CGS § 38a-490) (Effective January 1, 2012)	(a) [Every] Each individual health insurance policy delivered, issued for delivery, renewed, amended or continued in this state providing… (c)…[or] service corporation, medical service corporation or health care center [within] not later than…. [(d) The provisions of this section shall apply with respect to health insurance policies delivered or issued for delivery in this state on or after October 1, 1974, and to any health insurance policies which are thereafter amended to substantially alter or change benefits or coverages, and to any individual health insurance policies renewable at the option of such insurance company, hospital or medical service corporation or health care center which are thereafter renewed.]
	11-19, s. 36 (amending CGS § 38a-516) (Effective January 1, 2012)	(a) Each group health insurance policy delivered, issued for delivery, renewed, amended or continued in this state providing coverage.… (c)…[or] service corporation, medical service corporation or health care center [within] not later than thirty-one days after the date of birth…. [(d) The provisions of this section shall apply with respect to health insurance policies delivered or issued for delivery in this state on or after October 1, 1974, and to any health insurance policies which are thereafter amended to substantially alter or change benefits or coverages.]
	11-171, s. 3 (amending CGS § 38a-490) (Effective January 1, 2012)	(a) [Every] Each individual health insurance policy delivered, issued for delivery, renewed, amended or continued in this state…. (b)…[or] service corporation, medical service corporation or health care center [within thirty-one] not later than sixty-one days after the date of birth in order to continue coverage beyond such [thirty-one-day] sixty one-day period [(d) The provisions of this section shall apply with respect to health insurance policies delivered or issued for delivery in this state on or after October 1, 1974, and to any health insurance policies which are thereafter amended to substantially alter or change benefits or coverages, and to any individual health insurance policies renewable at the option of such insurance company, hospital or medical service corporation or health care center which are thereafter renewed.]

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.		
Mandate	**Public Act**	**Text**
	11-171, s. 4 (amending CGS § 38a-516) (Effective January 1, 2012)	(a) Each group health insurance policy <u>delivered, issued for delivery, renewed, amended or continued in this state,</u> providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and(12) of section 38a-469 for a family member of the insured or subscriber shall<u>, as to such family members' coverage,</u> also provide [as to such family members' coverage,] that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth…. (c) If payment of a specific premium fee is required to provide coverage for a child, the policy may require that notification of birth of such newly born child and payment of the required premium or fees shall be furnished to the insurer, hospital [or] <u>service corporation,</u> medical service corporation or health care center [within thirty-one] <u>not later than sixty-one</u> days after the date of birth in order to continue coverage beyond such [thirty-one-day] <u>sixty-one-day period,</u> provided failure to furnish such notice or pay such premium shall not prejudice any claim originating within such [thirty-one-day] <u>sixty-one-day</u> period. [(d) The provisions of this section shall apply with respect to health insurance policies delivered or issued for delivery in this state on or after October 1, 1974, and to any health insurance policies which are thereafter amended to substantially alter or change benefits or coverages.]
	12-145, s. 12, 13 (Effective from passage; approved June 15, 2012)	[members'] <u>member's</u>
Birth-to-three		
§ 38a-490a § 38a-516a	Sept. Sp. Sess. 09-3, s. 45, 46 (Effective from passage; approved October 6, 2009)	a maximum benefit of [three thousand two] <u>six thousand four</u> hundred dollars per child per year and an aggregate benefit of [nine thousand six] <u>nineteen thousand two</u> hundred dollars per child over the total three-year period
	11-44, s. 147 (amending CGS § 38a-490a) (Effective January 1, 2012)	Such policy shall provide [(1)] coverage…for a child from birth until the child's third birthday<u>.</u> [, and (2)] <u>No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such services, except that a high deductible plan, as that term is used in subsection (f) of section 38a-493, shall not be subject to the deductible limits set forth in this section. Such policy shall provide</u> a maximum benefit of six thousand four hundred dollars per child per year….

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.		
Mandate	**Public Act**	**Text**
	11-44, s. 148 (amending CGS § 38a-516a) (Effective January 1, 2012)	Such policy shall provide [(1)] coverage…for a child from birth until the child's third birthday, [, and (2)] No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such services, except that a high deductible plan, as that term is used in subsection (f) of section 38a-493, shall not be subject to the deductible limits set forth in this section. Such policy shall provide…, except that for a child with autism spectrum disorders, as defined in section 38a-514b, who is receiving early intervention services as defined in section 17a-248, the maximum benefit available through early intervention providers shall be fifty thousand dollars per child per year and an aggregate benefit of one hundred fifty thousand dollars per child over the total three-year period as provided for in section 38a-514b. Nothing in this section shall be construed to increase the amount of coverage required for autism spectrum disorders for any child beyond the amounts set forth in section 38a-514b. Any coverage provided for autism spectrum disorders through an individualized family service plan pursuant to section 17a-248e shall be credited toward the coverage amounts required under section 38a-514b.
	12-44, s. 1, 2 (Effective July 1, 2012)	(a)…issued for delivery, [or] renewed, amended or continued in this state [on or after July 1, 1996,]… (b)… (c)… (d) No payment made under this section shall (1) be applied by the insurer, health care center or plan administrator against or result in a loss of benefits due to any maximum lifetime or annual limits specified in the policy, [or health benefits plan] (2) adversely affect the availability of health insurance to the child, the child's parent or the child's family members insured under any such policy, or (3) be a reason for the insurer, health care center or plan administrator to rescind or cancel such policy. Payments made under this section shall not be treated differently than other claim experience for purposes of premium rating.

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.

Mandate	Public Act	Text
	13-84, s. 5, 6 (Effective from passage; approved June 5, 2013)	Such policy shall (1) provide coverage for such services provided by qualified personnel, as defined in section 17a-248, for a child from birth until the child's third birthday, and (2) maintain, for any insured diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", coverage for such services for the treatment of said disorder at the benefit levels, at a minimum, provided immediately preceding the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".
	14-235, s. 18 (amending CGS § 38a-490a) (Effective October 1, 2014)	except that a high deductible health plan
	14-235, s. 19 (amending CGS § 38a-516a) (Effective October 1, 2014)	a high deductible health plan, as that term is used in subsection (f) of section [38a-493] 38a-520,
Hearing aids for children twelve and under		
§ 38a-490b § 38a-516b	12-145, s. 47, 48 (Effective from passage; approved June 15, 2012)	[on or after October 1, 2001,]
Inpatient, outpatient, and one day dental services		
§ 38a-491a § 38a-517a	10-5, s. 20, 27 (Effective January 1, 2011)	, amended or continued in this state [on or after January 1, 2000,] shall
Hypodermic needles and syringes		
§ 38a-492a § 38a-518a	11-19, s. 37, 38 (Effective January 1, 2012)	[Every] Each individual health insurance…delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after July 1, 1992,]
Off-label use of certain drugs		
§ 38a-492b § 38a-518b	11-19, s. 39, 40 (Effective January 1, 2012)	, [or] renewed, amended or continued in this state [on or after October 1, 1994, which] that provides

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.		
Mandate	**Public Act**	**Text**
	11-172, s. 15, 16 (Effective January 1, 2012)	(a) Each group health insurance policy delivered, issued for delivery, [or] renewed, amended or continued in this state, [on or after October 1, 1994, which] that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for treatment of certain types of cancer or disabling or life-threatening chronic diseases, shall not exclude coverage of any such drug on the basis that such drug has been prescribed for the treatment of a type of cancer or a disabling or life-threatening chronic disease for which the drug has not been approved by the federal Food and Drug Administration, provided the drug is recognized for treatment of the specific type of cancer or a disabling or life-threatening chronic disease for which the drug has been prescribed in one of the following established reference compendia…. (b)…cancer or a disabling or life-threatening chronic disease for which the drug has been prescribed. (c) [Nothing] Except as specified, nothing in this section shall be construed to create…
Certain specialized foods		
§ 38a-492c § 38a-518c	12-145, s. 54, 55 (Effective January 1, 2013)	(b) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), [(6),] (11) and (12) of section 38a-469 delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after October 1, 1997,]… (c) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), [(6),] (11) and (12) of section 38a-469 delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after October 1, 2007,]…
Prescription drugs removed from formulary		
§ 38a-492f § 38a-518f	12-145, s. 56, 57 (Effective January 1, 2013)	amended or continued in this state [on or after January 1, 2000,]

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.

Mandate	Public Act	Text
Pain management		
§ 38a-492i § 38a-518i	11-169, s. 1, 2 (Effective January 1, 2012)	(a)… [on or after January 1, 2001,]…[which] that…. (b) (1) No such policy that provides coverage for prescription drugs shall require an insured to use, prior to using a brand name prescription drug prescribed by a licensed physician for pain treatment, any alternative brand-name prescription drugs or over-the-counter drugs. (2) Such policy may require an insured to use, prior to using a brand name prescription drug prescribed by a licensed physician for pain treatment, a therapeutically equivalent generic drug. (c)….
	12-197, s. 20, 21 (Effective from passage; approved June 15, 2012)	"pain management specialist" means a physician who is credentialed by the American Academy of Pain Management or who is a board-certified anesthesiologist, physiatrist, neurologist, oncologist or radiation oncologist with additional training in pain management.
Ostomy-related supplies		
§ 38a-492j § 38a-518j	10-5, s. 21, 28 (Effective January 1, 2011)	, amended or continued in this state [on or after October 1, 2000,] that
	11-204, s. 1, 2 (Effective January 1, 2012)	up to [one thousand] two thousand five hundred
Colorectal cancer screening		
§ 38a-492k § 38a-518k	11-83, s. 1 (amending CGS § 38a-492k) (Effective January 1, 2012)	(a)… after consultation with the American Cancer Society and the American College of Radiology, based on the ages, family histories and frequencies provided in the recommendations. [Benefits] Except as specified in subsection (b) of this section, benefits under this section shall be subject to the same terms and conditions applicable to all other benefits under such policies. (b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for any additional colonoscopy ordered in a policy year by a physician for an insured. The provisions of this subsection shall not apply to a high deductible health plan as that term is used in subsection (f) of section 38a-493.

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.		
Mandate	**Public Act**	**Text**
	11-83, s. 2 (amending CGS § 38a-518k) (Effective January 1, 2012)*	(a)…after consultation with the American Cancer Society and the American College of Radiology, based on the ages, family histories and frequencies provided in the recommendations. [Benefits] Except as specified in subsection (b) of this section, benefits under this section shall be subject to the same terms and conditions applicable to all other benefits under such policies. (b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for any additional colonoscopy ordered in a policy year by a physician for an insured. The provisions of this subsection shall not apply to a high deductible health plan as that term is used in subsection (f) of section 38a-520.
	12-61, s. 1, 2 (Effective January 1, 2013)	[American College of Gastroenterology, after consultation with the] American Cancer Society, [and the American College of Radiology,]
	12-190, s. 1, 2 (Effective January 1, 2013)	(b) No such policy shall impose: [a] (1) A deductible for a procedure that a physician initially undertakes as a screening colonoscopy or a screening sigmoidoscopy; or (2) A coinsurance, copayment, deductible or other out-of-pocket expense for any additional colonoscopy ordered in a policy year by a physician for an insured. The provisions of this [subsection] subdivision shall not apply to a high deductible health plan….
Home health care		
§ 38a-493 § 38a-520	11-19, s. 41 (amending CGS § 38a-493) (Effective January 1, 2012)	(a) [Every] Each individual health insurance policy…issued for delivery, [or] renewed, amended or continued in this state [on or after October 1, 1975,]
	11-19, s. 42 (amending CGS § 38a-520) (Effective January 1, 2012)	, [or] renewed, amended or continued in this state [on or after October 1, 1975,]
	11-19, s. 43 (amending CGS § 38a-493) (Effective January 1, 2012)	(j) [Every] Each individual major medical expense policy delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after October 1, 1989,]
	11-19, s. 44 (amending CGS § 38a-520) (Effective January 1, 2012)	, [or] renewed, amended or continued in this state [on or after October 1, 1989,]

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.

Mandate	Public Act	Text
Occupational therapy		
§ 38a-496 § 38a-524	11-19, s. 45 (amending CGS § 38a-496) (January 1, 2012)	[Every] Each individual health insurance policy…issued for delivery, [or] renewed, amended or continued in this state [on or after October 1, 1982, which] that provides coverage
	11-19, s. 46 (January 1, 2012)	, [or] renewed, amended or continued in this state [on or after October 1, 1982, which] that provides coverage
Ambulance services		
§ 38a-498 § 38a-525	12-145, s. 58, 59 (Effective January 1, 2013)	[or] amended or continued in this state [on or after October 1, 2002,]
Mobile field hospital		
§ 38a-498b § 38a-525b	12-145, s. 49, 50 (Effective from passage; approved June 15, 2012)	[the] this state [on or after July 1, 2005,]
Elevated blood alcohol content		
§ 38a-498c § 38a-525c	12-145, s. 51, 52 (Effective from passage; approved June 15, 2012)	[on or after October 1, 2006,]
Services of physician assistants and certain nurses		
§ 38a-499 § 38a-526	11-19, s. 47 (amending CGS § 38a-499) (January 1, 2012)	(b) [Every] Each individual health insurance policy…issued for delivery, [or] renewed, amended or continued in this state [on or after October 1, 1984,] shall provide coverage…hospital [or] service corporation,
	11-19, s. 48 (amending CGS § 38a-526) (January 1, 2012)	, [or] renewed, amended or continued in this state [on or after October 1, 1984,]…hospital [or] service corporation, medical service corporation…hospital [or] service corporation,
Breast cancer screening		
§ 38a-503 § 38a-530	12-150, s. 1, 2 (Effective from passage; approved June 15, 2012)	[which] that…(B) Magnetic resonance imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society, [or the American College of Radiology.]…
	14-97, s. 1, 2 (Effective January 1, 2015)	(c) [On and after October 1, 2009, each] Each , except that no such policy shall impose a copayment that exceeds a maximum of twenty dollars for an ultrasound screening under subparagraph (A) of subdivision (2) of subsection (a) of this section.

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.		
Mandate	**Public Act**	**Text**
Direct access to obstetrician-gynecologist		
§ 38a-503b § 38a-530b	10-32, s. 120, 121 (Effective from passage; approved May 10, 2010)	advanced practice registered nurses,
	11-19, s. 49 (amending CGS § 38a-503b) (Effective January 1, 2012)	(a) As used in this section, "carrier" means each insurer, health care center, hospital [and] service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, [or] amending or continuing any individual health insurance policy in this state [on or after October 1, 1995,]
	11-19, s. 50 (amending CGS § 38a-530b) (Effective January 1, 2012)	(a) As used in this section, "carrier" means each insurer, health care center, hospital [and] service corporation, medical service corporation[,] or other entity delivering, issuing for delivery, renewing, [or] amending or continuing any individual health insurance policy in this state [on or after October 1, 1995,]
Maternity minimum stay		
§ 38a-503c § 38a-530c	11-19, s. 51, 52 (Effective January 1, 2012)	[and] service corporation,…or continuing any individual health insurance policy in this state [on or after October 1, 1996,]
Mastectomy or lymph node dissection minimum stay		
§ 38a-503d § 38a-530d	11-19, s. 8, 9 (Effective October 1, 2011)	[on or after July 1, 1997,]
Prescription contraceptives		
§ 38a-503e §28a-530e	11-19, s. 53, 54 (Effective January 1, 2012)	, amended or continued in this state [on or after October 1, 1999,]
Tumors and leukemia		
§ 38a-504 § 38a-542	10-5, s. 24, 31 (Effective January 1, 2011)	[which] that delivers, [or] issues for delivery, renews, amends or continues…. (b)…for a nondental prosthesis

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.

Mandate	Public Act	Text
	10-63, s. 1, 2 (Effective January 1, 2011)	[which] that delivers, [or] issues for delivery, renews, amends or continues…. (b)…a nondental prosthesis, except that for purposes of the surgical removal of breasts due to tumors the yearly benefit for such prosthesis shall be at least three hundred dollars for each breast removed…. (d) (1) Each policy of the type specified in subsection (a) of this section that provides coverage for intravenously administered and orally administered anticancer medications used to kill or slow the growth of cancerous cells, that are prescribed by a prescribing practitioner, as defined in section 20-571, shall provide coverage for orally administered anticancer medications on a basis that is no less favorable than intravenously administered anticancer medications. (2) No insurance company, hospital service corporation, medical service corporation, health care center or fraternal benefit society that delivers, issues for delivery, renews, amends or continues in this state a policy of the type specified in subsection (a) of this section, shall reclassify such anticancer medications or increase the coinsurance, copayment, deductible or other out-of-pocket expense imposed under such policy for such medications, to achieve compliance with this subsection.
	11-19, s. 10, 11 (Effective October 1, 2011)	cancerous cells [,] that.… (2)…subsection (a) of this section [,] shall reclassify such anticancer medications…for such medications [,] to achieve
Clinical trials		
§ 38a-504a § 38a-542a	11-19, s. 57 (amending CGS § 38a-504a) (Effective January 1, 2012)	, [or] renewed, amended or continued in this state [on or after January 1, 2002,] shall provide coverage for the routine patient care costs, as defined in section 38a-504d, as amended by this act, associated with cancer clinical trials, in accordance with sections 38a-504b to 38a-504g, inclusive, as amended by this act. As used in this section and sections 38a-504b to 38a-504g, inclusive, as amended by this act,…for the prevention of cancer in human beings . [, except that a clinical trial for the prevention of cancer is eligible for coverage only if it involves a therapeutic intervention and is a phase III clinical trial approved by one of the entities identified in section 38a-504b and is conducted at multiple institutions.]

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.		
Mandate	**Public Act**	**Text**
	11-19, s. 62 (amending CGS § 38a-542a) (Effective January 1, 2012)	, [or] renewed, amended or continued in this state [on or after January 1, 2002,] shall provide coverage for the routine patient care costs, as defined in section 38a-542d, as amended by this act, associated with cancer clinical trials, in accordance with sections 38a-542b to 38a-542g, inclusive, as amended by this act. As used in this section and sections 38a-542b to 38a-542g, inclusive, as amended by this act, "cancer clinical trial" means an organized, systematic, scientific study… for the prevention of cancer in human beings. [, except that a clinical trial for the prevention of cancer is eligible for coverage only if it involves a therapeutic intervention and is a phase III clinical trial approved by one of the entities identified in section 38a-542b and is conducted at multiple institutions.]
	11-172, s. 1, 8 (Effective January 1, 2012)	, [or] renewed, amended or continued in this state, [on or after January 1, 2002,] shall provide coverage for the routine patient care costs, as defined in section 38a-504d, as amended by this act, associated with [cancer] clinical trials, in accordance with sections 38a-504b to 38a-504g, inclusive, as amended by this act. As used in this section and sections 38a-504b to 38a-504g, inclusive, as amended by this act, ["cancer clinical] "clinical trial" means 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, except that a clinical trial for the prevention of cancer is eligible for coverage only if it involves a therapeutic intervention and is a phase III clinical trial approved by one of the entities identified in section 38a-504b and is conducted at multiple institutions] or disabling or life-threatening chronic diseases in human beings.
Clinical trials		
§ 38a-504b § 38a-542b	11-19, s. 58, 63 (Effective January 1, 2012)	A clinical trial for the prevention of cancer shall be eligible for coverage only if it involves a therapeutic intervention, is a phase III clinical trial approved by one of the entities identified in this section, and is conducted at multiple institutions. In order to be eligible for coverage of routine patient care costs, as defined in section 38a-504d, as amended by this act, a cancer clinical trial shall be conducted under the auspices of an independent peer-reviewed protocol.…Nothing in sections 38a- 504a to 38a-504g, inclusive, as amended by this act,

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.		
Mandate	**Public Act**	**Text**
§ 38a-504b § 38a-542b	11-172, s. 2, 9 (Effective January 1, 2012)	as amended by this act, a [cancer] clinical trial shall be (1) conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by: [(1)] (A) One of the National Institutes of Health; [or (2)] (B) a National Cancer Institute affiliated cooperative group; [or (3)] (C) the federal Food and Drug Administration as part of an investigational new drug or device application or exemption; or [(4)] (D) the federal Department of Defense or Veterans Affairs; or (2) qualified to receive Medicare coverage of its routine costs under the Medicare Clinical Trial Policy established under the September 19, 2000, Medicare National Coverage Determination, as amended from time to time. Nothing in sections 38a-504a to 38a-504g, inclusive, as amended by this act, shall be construed to require coverage for any single institution [cancer] clinical trial conducted solely under the approval of the institutional review board of an institution, or any trial that is no longer approved by an entity identified in [subdivision (1), (2), (3) or (4) of this section] subparagraph (A), (B), (C) or (D) of subdivision (1) of this section.
Clinical trials		
§ 38a-504c § 38a-542c	11-19, s. 59, 64 (Effective January 1, 2012)	In order to be eligible for coverage of routine patient care costs, as defined in section 38a-504d, as amended by this act, the insurer, health care center or plan administrator may require that the person or entity seeking coverage for the cancer clinical trial provide: (1) Evidence satisfactory to the insurer… [and] (2) evidence that the appropriate informed consent has been received from the insured person; [and] (3) copies of any medical records, protocols, test results or other clinical information used by the physician or institution seeking to enroll the insured person in the cancer clinical trial; [and] (4) a summary of the anticipated routine patient care costs in excess of the costs for standard treatment; [and] (5) information from the physician or institution seeking to enroll the insured person.… The health plan or insurer shall request any additional information about a cancer clinical trial [within] not later than five business days [of] after receiving a request for coverage from an insured person or a physician seeking to enroll an insured person in a cancer clinical trial. Nothing in sections 38a-504a to 38a-504g, inclusive, as amended by this act, shall be construed to require the insurer or health care center to provide coverage for routine patient care costs that are eligible for reimbursement by an entity other than the insurer, including the entity sponsoring the cancer clinical trial.

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.		
Mandate	**Public Act**	**Text**
§ 38a-504c § 38a-542c	11-172, s. 3, 10 (Effective January 1, 2012)	In order to be eligible for coverage of routine patient care costs, as defined in section 38a-504d, as amended by this act, the insurer, health care center or plan administrator may require that the person or entity seeking coverage for the [cancer] clinical trial provide: (1) Evidence satisfactory to the insurer, health care center or plan administrator that the insured person receiving coverage meets all of the patient selection criteria for the [cancer] clinical trial, including credible evidence in the form of clinical or preclinical data showing that the [cancer] clinical trial is likely to have a benefit for the insured person that is commensurate with the risks of participation in the [cancer] clinical trial to treat the person's condition; [and] (2) evidence that the appropriate informed consent has been received from the insured person; [and] (3) copies of any medical records, protocols, test results or other clinical information used by the physician or institution seeking to enroll the insured person in the [cancer] clinical trial; [and] (4) a summary of the anticipated routine patient care costs in excess of the costs for standard treatment; [and] (5) information from the physician or institution seeking to enroll the insured person in the clinical trial regarding those items, including any routine patient care costs, that are eligible for reimbursement by an entity other than the insurer or health care center, including the entity sponsoring the clinical trial; and (6) any additional information that may be reasonably required for the review of a request for coverage of the [cancer] clinical trial. The health plan or insurer shall request any additional information about a [cancer] clinical trial [within] not later than five business days [of] after receiving a request for coverage from an insured person or a physician seeking to enroll an insured person in a [cancer] clinical trial. Nothing in sections 38a-504a to 38a-504g, inclusive, as amended by this act, shall be construed to require the insurer or health care center to provide coverage for routine patient care costs that are eligible for reimbursement by an entity other than the insurer, including the entity sponsoring the [cancer] clinical trial.
Clinical trials		
§ 38a-504d § 38a-542d	11-19, s. 60 (amending CGS § 38a-504d) (Effective January 1, 2012)	(a) For purposes of sections 38a-504a to 38a-504g, inclusive, as amended by this act, "routine patient care costs" means: (1) [Coverage for medically] Medically necessary health care services…hospitalization or other services provided to the [patient] insured person…and (2) [coverage for routine patient care] costs incurred for drugs provided to the insured person, in accordance with section [38a-518b] 38a-492b, as amended by this act, provided such drugs have been approved for sale by the federal Food and Drug Administration.

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.

Mandate	Public Act	Text
§ 38a-504d § 38a-542d	11-19, s. 65 (amending CGS § 38a-542d) (Effective January 1, 2012)	(a) For purposes of sections 38a-542a to 38a-542g, inclusive, as amended by this act, "routine patient care costs" means: (1) [Coverage for medically] Medically necessary health care services that are…hospitalization or other services provided to the [patient] insured person… and (2) [coverage for routine patient care] costs incurred for drugs provided to the insured person, in accordance with section 38a-518b, as amended by this act, provided such drugs have been approved for sale by the federal Food and Drug Administration.
	11-172, s. 4 (amending CGS § 38a-504d) (Effective January 1, 2012)	(a) For purposes of sections 38a-504a to 38a-504g, inclusive, as amended by this act, "routine patient care costs" means: (1) [Coverage for medically] Medically necessary health care services that are incurred as a result of the treatment being provided to the insured person for purposes of the [cancer] clinical trial that would otherwise be covered if such services were not rendered pursuant to a [cancer] clinical trial. Such services shall include those rendered by a physician, diagnostic or laboratory tests, hospitalization or other services provided to the [patient] insured person during the course of treatment in the [cancer] clinical trial for a condition, or one of its complications, that is consistent with the usual and customary standard of care and would be covered if the insured person were not enrolled in a [cancer] clinical trial. Such hospitalization shall include treatment at an out-of-network facility if such treatment is not available in-network and not eligible for reimbursement by the sponsors of such clinical trial, [;] and (2) [coverage for routine patient care] costs incurred for drugs provided to the insured person, in accordance with section [38a-518b] 38a-492b, as amended by this act, provided such drugs have been approved for sale by the federal Food and Drug Administration. (b) Routine patient care costs shall be subject to the terms, conditions, restrictions, exclusions and limitations of the contract or certificate of insurance between the [subscriber] insured person and the insurer or health plan, including limitations on out-of-network care, except that treatment at an out-of-network hospital as provided in subdivision (1) of subsection (a) of this section shall be made available by the out-of-network hospital and the insurer or health care center at no greater cost to the insured person than if such treatment was available in-network. The insurer or health care center may require that any routine tests or services required under the [cancer] clinical trial protocol be performed by providers or institutions under contract with the insurer or health care center.

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.		
Mandate	**Public Act**	**Text**
§ 38a-504d § 38a-542d	11-172, s. 4 (amending CGS § 38a-504d) (Effective January 1, 2012)	(c) Notwithstanding the provisions of subsection (a) of this section, routine patient care costs shall not include: (1) The cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration; (2) the cost of a non-health-care service that an insured person may be required to receive as a result of the treatment being provided for the purposes of the [cancer] clinical trial; (3) facility, ancillary, professional services and drug costs that are paid for by grants or funding for the [cancer] clinical trial; (4) costs of services that (A) are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or (B) are performed specifically to meet the requirements of the [cancer] clinical trial; (5) costs that would not be covered under the insured person's policy for noninvestigational treatments, including, but not limited to, items excluded from coverage under the insured person's contract with the insurer or health plan; and (6) transportation, lodging, food or any other expenses associated with travel to or from a facility providing the [cancer] clinical trial, for the insured person or any family member or companion.
	11-172, s. 11 (amending CGS § 38a-542d) (Effective January 1, 2012)	(a) For purposes of sections 38a-504a to 38a-504g, inclusive, <u>as amended by this act</u>, "routine patient care costs" means: (1) [Coverage for medically] <u>Medically</u> necessary health care services that are incurred as a result of the treatment being provided to the insured person for purposes of the [cancer] clinical trial that would otherwise be covered if such services were not rendered pursuant to a [cancer] clinical trial. Such services shall include those rendered by a physician, diagnostic or laboratory tests, hospitalization or other services provided to the [patient] <u>insured person</u> during the course of treatment in the [cancer] clinical trial for a condition, or one of its complications, that is consistent with the usual and customary standard of care and would be covered if the insured person were not enrolled in a [cancer] clinical trial. Such hospitalization shall include treatment at an out-of-network facility if such treatment is not available in-network and not eligible for reimbursement by the sponsors of such clinical trial, [;] and (2) [coverage for routine patient care] costs incurred for drugs provided to the insured person, in accordance with section 38a-518b, <u>as amended by this act</u>, provided such drugs have been approved for sale by the federal Food and Drug Administration.

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.

Mandate	Public Act	Text
§ 38a-504d § 38a-542d	11-172, s. 11 (amending CGS § 38a-542d) (Effective January 1, 2012)	(b) Routine patient care costs shall be subject to the terms, conditions, restrictions, exclusions and limitations of the contract or certificate of insurance between the [subscriber] <u>insured person</u> and the insurer or health plan, including limitations on out-of-network care, except that treatment at an out-of-network hospital as provided in subdivision (1) of subsection (a) of this section shall be made available by the out-of-network hospital and the insurer or health care center at no greater cost to the insured person than if such treatment was available in-network. The insurer or health care center may require that any routine tests or services required under the [cancer] clinical trial protocol be performed by providers or institutions under contract with the insurer or health care center. (c) Notwithstanding the provisions of subsection (a) of this section, routine patient care costs shall not include: (1) The cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration; (2) the cost of a non-health-care service that an insured person may be required to receive as a result of the treatment being provided for the purposes of the [cancer] clinical trial; (3) facility, ancillary, professional services and drug costs that are paid for by grants or funding for the [cancer] clinical trial; (4) costs of services that (A) are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or (B) are performed specifically to meet the requirements of the [cancer] clinical trial; (5) costs that would not be covered under the insured person's policy for noninvestigational treatments, including, but not limited to, items excluded from coverage under the insured person's contract with the insurer or health plan; and (6) transportation, lodging, food or any other expenses associated with travel to or from a facility providing the [cancer] clinical trial, for the insured person or any family member or companion.

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.		
Mandate	**Public Act**	**Text**
Clinical Trials		
§ 38a-504e § 38a-542e	11-172, s. 5, 12 (Effective January 1, 2012)	(a) Providers, hospitals and institutions that provide routine patient care services as set forth in subsection (a) of section 38a-504d, as amended by this act, as part of a [cancer] clinical trial that meets the requirements of sections 38a-504a to 38a-504g, inclusive, as amended by this act, and is approved for coverage by the insurer or health care center shall not bill the insurer or health care center or the insured person for any facility, ancillary or professional services or costs that are not routine patient care services as set forth in subsection (a) of section 38a-504d, as amended by this act, or for any product or service that is paid by the entity sponsoring or funding the [cancer] clinical trial.… (c) Providers, hospitals or institutions that have contracts with the insurer or health care center to render covered routine patient care services to insured persons as part of a [cancer] clinical trial [may] shall not bill the insured person for the cost of any covered routine patient care service. (d) Providers, hospitals or institutions that do not have a contract with the insurer or health care center to render covered routine patient care services to insured persons as part of a [cancer] clinical trial [may] shall not bill the insured person for the cost of any covered routine patient care service. . . . (f) Pursuant to subsection (b) of section 38a-504d, as amended by this act, insurers or health care centers shall be required to pay providers, hospitals and institutions that do not have a contract with the insurer or health care center to render covered routine patient care services to insured persons the lesser of (1) the lowest contracted per diem, fee schedule rate or case rate that the insurer or health care center pays to any participating provider in the state of Connecticut for similar in-network services, or (2) the billed charges. Providers, hospitals or institutions [may] shall not collect any amount more than the total amount paid by the insurer or health care center and the insured person in the form of a deductible or copayment set forth in the insured person's contract. Such amount shall be deemed by the provider, hospital or institution to be payment in full.

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.

Mandate	Public Act	Text
Clinical Trials		
§ 38a-504f § 38a-542f	11-19, s. 61 (amending § 38a-504f) (Effective January 1, 2012)	shall approve or deny coverage for such services [within] not later than five business days [of] after receiving such request and any other reasonable supporting materials requested by the insurer or health plan pursuant to section 38a-504c, as amended by this act, except that an insurer or health care center that utilizes independent experts to review such requests shall respond [within] not later than ten business days after receiving such request and supporting materials. Requests for coverage of phase III clinical trials for the prevention of cancer pursuant to section [38a-504a] 38a-504b, as amended by this act, shall be approved or denied [within] not later than fourteen business days after receiving such request and supporting materials.
	11-19, s. 66 (amending § 38a-542f) (Effective January 1, 2012)	shall approve or deny coverage for such services [within] not later than five business days [of] after receiving such request and any other reasonable supporting materials requested by the insurer or health plan pursuant to section 38a-504c, as amended by this act, except that an insurer or health care center that utilizes independent experts to review such requests shall respond [within] not later than ten business days after receiving such request and supporting materials. Requests for coverage of phase III clinical trials for the prevention of cancer pursuant to section [38a-542a] 38a-542b, as amended by this act, shall be approved or denied [within] not later than fourteen business days after receiving such request and supporting materials.
	11-58, s. 83, 84 (Effective July 1, 2011)	pursuant to section [38a-478n] 60 of this act.

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.		
Mandate	**Public Act**	**Text**
§ 38a-504f § 38a-542f	11-172, s. 6, 13 (Effective January 1, 2012)	(a) (1)…An insurer or health care center [may] shall not substitute any other approval request form for the form developed by the department, except that any insurer or health care center that has entered into an agreement to provide coverage for cancer clinical trials approved pursuant to section 38a-504g, as amended by this act, may use the form or process established by such agreement. (2) For purposes of clinical trials other than cancer clinical trials, the Insurance Department, in cooperation with at least one state nonprofit research or advocacy organization concerned with the subject of the clinical trial, at least one national nonprofit research or advocacy organization concerned with the subject of the clinical trial, the Connecticut Association of Health Plans and Anthem Blue Cross of Connecticut, shall develop a standardized form that all providers, hospitals and institutions shall submit to the insurer or health care center when seeking to enroll an insured person in a clinical trial. An insurer or health care center shall not substitute any other approval request form for the form developed by the department, except that any insurer or health care center that has entered into an agreement to provide coverage for clinical trials approved pursuant to section 38a-504g, as amended by this act, may use the form or process established by such agreement. (b) Any insurer or health care center that receives the department form from a provider, hospital or institution seeking coverage for the routine patient care costs of an insured person in a [cancer] clinical trial shall approve or deny coverage for such services [within] not later than five business days [of] after receiving such request and any other reasonable supporting materials requested by the insurer or health plan pursuant to section 38a-504c, as amended by this act, except that an insurer or health care center that utilizes independent experts to review such requests shall respond [within] not later than ten business days after receiving such request and supporting materials. [Requests for coverage of phase III clinical trials for the prevention of cancer pursuant to section 38a-504a shall be approved or denied within fourteen business days.] (c)…the [cancer] clinical trial….
	12-145, s. 21 (amending CGS § 38a-542f) (Effective from passage; approved June 15, 2012)	pursuant to section [38a- 504g] 38a-542g, as amended by this act,

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.

Mandate	Public Act	Text
Clinical trials		
§ 38a-504g § 38a-542g	11-172, s. 7, 14 (Effective January 1, 2012)	(a) Any insurer or health care center with coverage policies for care in [cancer] clinical trials shall submit such policies to the Insurance Department for evaluation and approval. The department shall certify whether the insurer's or health care center's coverage policy for routine patient care costs associated with [cancer] clinical trials is substantially equivalent to the requirements of sections 38a-504a to 38a-504g, inclusive, as amended by this act. If the department finds that such coverage is substantially equivalent to the requirements of sections 38a-504a to 38a-504g, inclusive, as amended by this act, the insurer or health care center shall be exempt from the provisions of sections 38a- 504a to 38a-504g, inclusive, as amended by this act…. (c) Any insurer or health care center coverage policy found by the department not to be substantially equivalent to the requirements of sections 38a-504a to 38a-504g, inclusive, as amended by this act, shall abide by the requirements of sections 38a-504a to 38a-504g, inclusive, as amended by this act, until the insurer or health care center has received such certification by the department.
	12-145, s. 16 (amending CGS § 38a-504g) (Effective from passage; approved June 12, 2012)	(a)…sections 38a-504a to [38a-504g] 38a-504f, inclusive. If the department finds that such coverage is substantially equivalent to the requirements of sections 38a-504a to [38a-504g] 38a-504f, inclusive, as amended by this act, the insurer or health care center shall be exempt from the provisions of sections 38a-504a to [38a-504g] 38a-504f, inclusive.… (c)…sections 38a-504a to [38a-504g] 38a-504f, inclusive, shall abide by the requirements of sections 38a-504a to [38a-504g] 38a-504f, inclusive, until the insurer or health care center has received such certification by the department.
§ 38a-504g § 38a-542g	12-145, s. 17 (amending CGS § 38a-542g) (Effective from passage; approved June 12, 2012)	(a)…sections 38a-542a to [38a-542g] 38a-542f, inclusive, as amended by this act. If the department finds that such coverage is substantially equivalent to the requirements of sections 38a-542a to [38a-542g] 38a-542f, inclusive, as amended by this act, the insurer or health care center shall be exempt from the provisions of sections 38a- 542a to [38a-542g] 38a-542f, inclusive, as amended by this act…. (c)…sections 38a-542a to [38a-542g] 38a-542f, inclusive, as amended by this act, shall abide by the requirements of sections 38a-542a to [38a-542g] 38a-542f, inclusive, as amended by this act, until the insurer or health care center has received such certification by the department.

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.		
Mandate	**Public Act**	**Text**
Clinical trials		
§ 38a-507 § 38a-534	11-19, s. 55, 56 (Effective January 1, 2012)	[Every] Each individual health insurance policy delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after October 1, 1989,]…under such policy,
Mail order pharmacies and step therapy		
§ 38a-510 § 38a-544	14-118, s. 1 (amending CGS § 38a-510) (Effective January 1, 2015	(a) No [health insurance policy issued on an individual basis, whether issued by an] insurance company, [a] hospital service corporation, [a] medical service corporation, [or a] health care center [, which] or other entity delivering, issuing for delivery, renewing, amending or continuing an individual health insurance policy or contract that provides coverage for prescription drugs may: [require any] (1) Require any person covered under such policy or contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for such drugs; [.] or (2) Require, if such insurance company, hospital service corporation, medical service corporation, health care center or other entity uses step therapy for such drugs, the use of step therapy for any prescribed drug for longer than sixty days. At the expiration of such time period, an insured's treating health care provider may deem such step therapy drug regimen clinically ineffective for the insured, at which time the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract. If such provider does not deem such step therapy drug regimen clinically ineffective or has not requested an override pursuant to subdivision (1) of subsection (b) of this section, such drug regimen may be continued.

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.

Mandate	Public Act	Text
§ 38a-510 § 38a-544	14-118, s. 1 (amending CGS § 38a-510) (Effective January 1, 2015	For purposes of this section, "step therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are to be prescribed. [(b) The provisions of this section shall apply to any such policy delivered, issued for delivery, renewed, amended or continued in this state on or after July 1, 2005.] (b) (1) Notwithstanding the sixty-day period set forth in subdivision (2) of subsection (a) of this section, each insurance company, hospital service corporation, medical service corporation, health care center or other entity that uses step therapy for such prescription drugs shall establish and disclose to its health care providers a process by which an insured's treating health care provider may request at any time an override of the use of any step therapy drug regimen. Any such override process shall be convenient to use by health care providers and an override request shall be expeditiously granted when an insured's treating health care provider demonstrates that the drug regimen required under step therapy (A) has been ineffective in the past for treatment of the insured's medical condition, (B) is expected to be ineffective based on the known relevant physical or mental characteristics of the insured and the known characteristics of the drug regimen, (C) will cause or will likely cause an adverse reaction by or physical harm to the insured, or (D) is not in the best interest of the insured, based on medical necessity. (2) Upon the granting of an override request, the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract. (c) Nothing in this section shall (1) preclude an insured or an insured's treating health care provider from requesting a review under sections 38a-591c to 38a-591g, inclusive, or (2) affect the provisions of section 38a-492i.

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.		
Mandate	**Public Act**	**Text**
§ 38a-510 § 38a-544	14-118, s. 2 (amending CGS § 38a-544) (Effective January 1, 2015	(a) No [health insurance policy issued on an individual basis, whether issued by an] insurance company, [a] hospital service corporation, [a] medical service corporation, [or a] health care center [, which] or other entity delivering, issuing for delivery, renewing, amending or continuing an individual health insurance policy or contract that provides coverage for prescription drugs may: [require any] (1) Require any person covered under such policy or contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for such drugs; [.] or (2) Require, if such insurance company, hospital service corporation, medical service corporation, health care center or other entity uses step therapy for such drugs, the use of step therapy for any prescribed drug for longer than sixty days. At the expiration of such time period, an insured's treating health care provider may deem such step therapy drug regimen clinically ineffective for the insured, at which time the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract. If such provider does not deem such step therapy drug regimen clinically ineffective or has not requested an override pursuant to subdivision (1) of subsection (b) of this section, such drug regimen may be continued. For purposes of this section, "step therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are to be prescribed. [(b) The provisions of this section shall apply to any such policy delivered, issued for delivery, renewed, amended or continued in this state on or after July 1, 2005.] (b) (1) Notwithstanding the sixty-day period set forth in subdivision (2) of subsection (a) of this section, each insurance company, hospital service corporation, medical service corporation, health care center or other entity that uses step therapy for such prescription drugs shall establish and disclose to its health care providers a process by which an insured's treating health care provider may request at any time an override of the use of any step therapy drug regimen. Any such override process shall be convenient to use by health care providers and an override request shall be expeditiously granted when an insured's treating health care provider

Table 4. Connecticut Health Benefit Mandates that were amended after CPHHP review.		
Mandate	**Public Act**	**Text**
§ 38a-510 § 38a-544	14-118, s. 2 (amending CGS § 38a-544) (Effective January 1, 2015	(A) has been ineffective in the past for treatment of the insured's medical condition, (B) is expected to be ineffective based on the known relevant physical or mental characteristics of the insured and the known characteristics of the drug regimen, (C) will cause or will likely cause an adverse reaction by or physical harm to the insured, or (D) is not in the best interest of the insured, based on medical necessity. (2) Upon the granting of an override request, the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract. (c) Nothing in this section shall (1) preclude an insured or an insured's treating health care provider from requesting a review under sections 38a-591c to 38a-591g, inclusive, or (2) affect the provisions of section 38a-518i.
Co-payments regarding in-network imaging services		
§ 38a-511 § 38a-550	10-5, s. 25 (amending CGS § 38a-511) (Effective from passage; approved May 5, 2010)	section [38a-520] 38a-493.

Table 5. Connecticut Mandated Health Benefits and EHB Categories			
Mandate	**Individual**	**Group**	**EHB Category**
Psychotropic drug availability	38a-476b	38a-476b	(6) Prescription Drugs
Experimental treatments	38a-483c	38a-513b	(1) Ambulatory Patient Services (3) Hospitalization (6) Prescription Drugs (8) Laboratory Services
Mental or nervous conditions	38a-488a	38a-514	(1) Ambulatory Patient Services (2) Emergency Services (3) Hospitalization (5) Mental Health (6) Prescription Drugs
Autism spectrum disorder therapies	38a-488b	38a-514b	(1) Ambulatory Patient Services (5) Mental Health (6) Prescription Drugs (7) Rehabilitative and Habilitative (10) Pediatric Services
Coverage for newborns	*38a-490*	*38a-516*	(1) Ambulatory Patient Services (2) Emergency Services (3) Hospitalization (4) Maternity and Newborn Care (6) Prescription Drugs (8) Laboratory Services (9) Preventive and Wellness (10) Pediatric Services
Birth-to-three	38a-490a	38a-516a	(5) Mental Health (7) Rehabilitative and Habilitative (9) Preventive and Wellness (10) Pediatric Services
Hearing aids for children twelve and under	38a-490b	38a-516b	(7) Rehabilitative and Habilitative (10) Pediatric Services
Craniofacial disorders	38a-490c	38a-516c	(1) Ambulatory Patient Services (3) Hospitalization (4) Maternity and Newborn Care (10) Pediatric Services
Blood lead screening and risk assessment	38a-490d	38a-535	(1) Ambulatory Patient Services (8) Laboratory Services (9) Preventive and Wellness (10) Pediatric Services
*Services performed by a dentist**	*38a-491*	*38a-517*	(1) Ambulatory Patient Services
Inpatient, outpatient, and one-day dental services	38a-491a	38a-517a	(1) Ambulatory Patient Services (2) Emergency Services (3) Hospitalization

Italicized font indicates the mandate is not a state-required benefit
*These statutory sections have not been reviewed by CPHHP.

Table 5. Connecticut Mandated Health Benefits and EHB Categories

Mandate	Individual	Group	EHB Category
Accidental ingestion of controlled drugs	38a-492	38a-518	(2) Emergency Services (3) Hospitalization
Hypodermic needles and syringes	38a-492a	38a-518a	(6) Prescription Drugs
Off-label use of certain drugs	38a-492b	38a-518b	(6) Prescription Drugs
Certain specialized foods	38a-492c	38a-518c	(4) Maternity and Newborn Care (6) Prescription Drugs (9) Preventive and Wellness (10) Pediatric Services
Diabetes testing and treatment	38a-492d	38a-518d	(1) Ambulatory Patient Services (6) Prescription Drugs (8) Laboratory Services (9) Preventive and Wellness
Diabetes self-management training	38a-492e	38a-518e	(9) Preventive and Wellness
Prescription drugs removed from formulary	*38a-492f*	*38a-518f*	(6) Prescription Drugs
Prostate cancer screening and treatment	38a-492g	38a-518g	(1) Ambulatory Patient Services (3) Hospitalization (6) Prescription Drugs (8) Laboratory Services
Lyme disease treatments	38a-492h	38a-518h	(1) Ambulatory Patient Services (6) Prescription Drugs (8) Laboratory Services
Pain management	38a-492i	38a-518i	(1) Ambulatory Patient Services (6) Prescription Drugs (9) Preventive and Wellness
Ostomy-related supplies	38a-492j	38a-518j	(7) Rehabilitative and Habilitative
Colorectal cancer screening	38a-492k	38a-518k	(1) Ambulatory Patient Services (8) Laboratory Services (9) Preventive and Wellness
Neuropsychological testing for children diagnosed with cancer	38a-492l	38a-516d	(1) Ambulatory Patient Services (5) Mental Health (10) Pediatric Services
Wound care for epidermolysis bullosa*	38a-492n	38a-518m	(1) Ambulatory Patient Services (9) Preventive and Wellness
Bone marrow testing	38a-492o	38a-518o	(3) Hospitalization (8) Laboratory Services
Home health care	38a-493	38a-520	(7) Rehabilitative and Habilitative (9) Preventive and Wellness
Occupational therapy	38a-496	38a-524	(1) Ambulatory Patient Services (7) Rehabilitative and Habilitative

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Table 5. Connecticut Mandated Health Benefits and EHB Categories			
Mandate	**Individual**	**Group**	**EHB Category**
Ambulance services	38a-498	38a-525	(2) Emergency Services (3) Hospitalization
Mobile field hospital	*38a-498b*	*38a-525b*	(2) Emergency Services (3) Hospitalization
Elevated blood alcohol content	*38a-498c*	*38a-525c*	(2) Emergency Services
Services of physician assistants and certain nurses	*38a-499*	*38a-526*	(1) Ambulatory Patient Services (2) Emergency Services (3) Hospitalization (4) Maternity and Newborn Care (5) Mental Health
Services Provided by the Veterans' Home	*38a-502*	*38a-529*	(3) Hospitalization (5) Mental Health (7) Rehabilitative and Habilitative (9) Preventive and Wellness
Breast cancer screening	38a-503	38a-530	(1) Ambulatory Patient Services (8) Laboratory Services (9) Preventive and Wellness
Direct Access to obstetrician-gynecologists	*38a-503b*	*38a-530b*	(1) Ambulatory Patient Services (4) Maternity and Newborn Care
Maternity minimum stay	38a-503c	38a-530c	(3) Hospitalization (4) Maternity and Newborn Care
Mastectomy or lymph node dissection minimum stay	38a-503d	38a-530d	(3) Hospitalization
Prescription contraceptives	38a-503e	38a-530e	(6) Prescription Drugs
Tumors and leukemia	38a-504	38a-542	(1) Ambulatory Patient Services (3) Hospitalization (6) Prescription Drugs (8) Laboratory Services (9) Preventive and Wellness
Clinical trials	38a-504a *et seq.*	38a-542a *et seq.*	(1) Ambulatory Patient Services (3) Hospitalization (6) Prescription Drugs (8) Laboratory Services
Chiropractic services	*38a-507*	*38a-534*	(1) Ambulatory Patient Services (7) Rehabilitative and Habilitative
Infertility diagnosis and treatment	38a-509	38a-536	(1) Ambulatory Patient Services (3) Hospitalization (6) Prescription Drugs (8) Laboratory Services
Mail order pharmacies and step therapy	38a-510	38a-544	(6) Prescription Drugs

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Table 5. Connecticut Mandated Health Benefits and EHB Categories

Mandate	Individual	Group	EHB Category
Co-payments regarding in-network imaging services	*38a-511*	*38a-550*	(8) Laboratory Services
*Co-payments for physical therapy and occupational therapy**	*38a-511a*	*38a-550a*	(1) Ambulatory Patient Services (7) Rehabilitative and Habilitative
Rehabilitative services (mandatory offer)	*(group only)*	*38a-523*	(1) Ambulatory Patient Services (5) Mental Health (6) Prescription Drugs (7) Rehabilitative and Habilitative
Medical complications of alcoholism	(group only)	38a-533	(1) Ambulatory Patient Services (2) Emergency Services (6) Prescription Drugs (9) Preventive and Wellness
Preventive pediatric care	(group only)	38a-535	(1) Ambulatory Patient Services (4) Maternity and Newborn Care (5) Mental Health (9) Preventive and Wellness (10) Pediatric Services
Maternity benefits and pregnancy care following policy termination	*(group only)*	*38a-547*	(1) Ambulatory Patient Services (2) Emergency Care (4) Maternity and Newborn Care

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ACTUARIAL REPORT FOR THE STATE OF CT

HEALTH INSURANCE MANDATE REVIEW

2016 Projected Cost Estimates

FINAL

February 13, 2015

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

This report serves to record the findings of Optum pursuant to our engagement to provide actuarial services to the State of CT in conjunction with Public Act 09-179. It is intended to communicate the results of our work.

In this report, Optum will provide a 2016 cost estimate for all existing mandates that were previously reviewed. The updated cost estimate is based on more recent claims experience. In addition, this report provides Optum's recommendation on mandates that are no longer cost effective, medically necessary, and those mandates in which there is an overlap of covered services.

Current Essential Health Benefits ("EHB") are based on state determined benchmark plans as identified and selected in 2012 and applied to 2014 and 2015 plans. It is anticipated that the US Health and Human Services Department ("HHS") will review EHBs in 2014 and make a determination as to whether EHBs for 2016 plans, filed with regulators for approval in first quarter 2015, will continue to be set by the states or by the federal government. Accordingly, the Insurance Department has requested Connecticut Center for Public Health and Health Policy (CPHHP) to conduct a review in conjunction with Optum of all existing and previously reviewed mandated health benefits as defined by Connecticut General Statute S38a-21(a)(2).

Optum is pleased to have been chosen to serve the State of CT in this valuable project. A team approach has been employed, both internally at Optum and with the workgroup that includes the CT Insurance Department and the CT Center for Public Health and Health Policy. Dimple Ambooken, FSA, MAAA and Michelle Roark, FSA, MAAA of Optum in New York, NY managed the actuarial work for this project. Dr. Thomas Knabel, MD was responsible for clinical guidance and support. Support staff in Chicago (Jiao Chen) and New York, NY (Dorothy Wu, Derek Miazga and Andrew Ho) carried out the data research that involved Optum's extensive commercial health claims databases.

Optum reviewed a total of 46 mandates (shown on the following two pages). In reporting the medical and/or prescription drug cost of the mandate, the cost shown is Paid Cost, which is the cost actually borne by the medical insurers and HMOs. The focus in this report is on the Paid cost because it is the primary ingredient of health insurance premiums. In addition to Paid cost, there is another cost that is the amount borne by the member in the form of deductibles, coinsurance, and copays. The cost that is the responsibility of the insured members is referred to as Cost Sharing. The sum of these two costs, Paid + Cost Sharing, is referred to as Allowed Cost.

The term de minimis is used to describe the projected cost of any mandate that we expect to be $0.05 per member per month (PMPM) or less when the cost is spread to all the insured people covered by the plan. The terms per person per month and per insured person per month mean the same thing as per member per month (PMPM).

II. METHODOLOGY

A. DATA

Prior Cost Estimates

The primary data source for prior estimates was provided by the CT domiciled carriers, all of which are subject to the mandates for their fully insured business. Six carriers provided their cost data for each mandate based on a 2007 and 2008 allowed and paid basis. There were far more members in the group data than in individual plans; thus the group data was substantially more credible than the individual data. A weighted average was developed across all six carriers using the relative number of member months as the weights. If a carrier had 25% of the total member months, for example, then its PMPM was weighted at 25% in the average.

The cost shown by the carriers represents the full cost of all care mentioned in the mandate, even though a significant portion of the mandated services might have been covered prior to the mandate or in the absence of the mandate. When carriers selected the claims covered by the mandate, the variation reported likely represents some degree of judgment in selecting the claims. The carriers' 2007 and 2008 data was used to develop 2010 cost estimates, which were then projected to 2016.

Revised Cost Estimates

The updated 2016 cost estimates are developed based on Optum data extracted for 2012-2013 using group data. The database captured approximately 275,000 covered lives for CT. Additional internal data sources were also reviewed in order to establish incidence and prevalence rates, utilization levels, unit cost of services, and overall spending on types of service. Optum used CT-specific health claims data for the 2016 revised cost estimates.

B. 2016 PROJECTION

Prior Cost Estimates

Prior cost estimates were trended to 2016 using trend assumptions cited in the original report. Prior year reports include a 5-year projection, which assumes an underlying PMPM and/or utilization trend. The 5-year projection for all mandates assumed an annual 5% PMPM trend, except for the following:

1. Psychotropic drugs [2010 report] = 7.5% annual PMPM trend

2. Mammography and Breast Ultrasound
    a. Coverage of Mammogram and Breast Ultrasound [2010 report] = 5% annual PMPM trend

    b. MRI for Breast Cancer Screening [2011 report]
        i. 5% annual PMPM trend plus
        ii. 10% annual utilization increase

3. Autism Spectrum Disorders [2012 report]
    a. Autism Spectrum Disorder
        i. 6% annual PMPM trend plus
        ii. 10% annual utilization increase

Revised Cost Estimates

Trend assumptions for revised cost estimates are consistent with the annual trends provided by the CT DOI based on recent DOI filings. Optum assumed a 6% annual PMPM trend for 2012-2014 and a 7% annual PMPM trend for 2015. The increase in trend assumption in 2015 is due to FDA approval of a new drug, Sovaldi, used to treat Hepatitis C. The cost of the drug is $1,000 per pill to be taken daily or $84,000 for a standard 12-week treatment course. Although the industry anticipates treatment of Hepatitis C will have a favorable impact on long-term health care costs, the magnitude is not yet known.

III. ACTUARIAL REPORT

This section provides a summary of the prior and revised 2016 Paid PMPM cost for each of the 46 mandates. The prior estimates are based on the 5-year projection in prior year reports, and were developed from 2007 and 2008 carrier data. The revised estimates are based on 2012 and 2013 Optum claims data, trended to 2016. Section III(B) comments on mandates where there is a notable difference between the prior and revised 2016 estimate. Section III(C) comments on mandates with de minimis cost.

The term de minimis is used to describe the projected incremental cost of any mandate that we expect to be $0.05 per member per month (PMPM) or less when the cost is spread to all the insured people covered by the plan.

A. 2016 Prior versus Revised PMPM Estimates

In the estimates below, a point estimate of cost is presented. This is not meant to imply a false sense of precision by providing a best estimate. While the actual 2013 cost is known, the projected 2016 cost may be somewhat greater or less than the values projected.

All of the following 46 mandates have been reviewed. The PMPM costs presented in this section apply to both Group and Individual policies, unless the mandate specifically states for Group only policies.

The tables below give the original 5th year projection for each mandate (A), the 5th year projection extended to 2016 using the same cost trend as was used in the initial review (B), and a new 2016 projection based on actual claims data for 2012 and 2013 from the Optum database (C).

Note: The numbering of the following mandates does not reflect their relative importance.

		2016 Projected Costs PMPM		
	Mandate	Prior Report 5th year estimate (A)	Trended to 2016 (B = A * Trend)	Revised estimate (C)
1	Diabetes Self-Management Training	$0.07	$0.08	$0.01
2	Prostate Cancer Screening *	$0.23	$0.25	$1.93
3	Ostomy-Related Supplies	$0.07	$0.08	$0.10
4	Hearing Aids for Children Twelve and Under	$0.01	$0.01	$0.00
5	Craniofacial Disorders	$0.02	$0.03	$0.13
6	Inpatient, Outpatient or One-day Dental Services	$0.06	$0.07	$0.00
7	Diabetes Testing and Treatment *	$5.59	$6.16	$10.25
8	Birth to Three Program	$0.27	$0.29	$0.04
9	Lyme Disease Treatments	$0.34	$0.38	$0.34
10	Colorectal Cancer Screening	$4.71	$4.56	$4.33
11	Tumors and Leukemia *	$13.37	$14.74	$36.72
12	Mammography and Breast Ultrasound *	$3.24	$4.58	$2.70
13	Maternity Minimum Stay *	$2.25	$2.48	$1.00
14	Mastectomy or Lymph Node Dissection Minimum Stay	$0.12	$0.13	$0.01
15	Prescription Contraceptives	$1.46	$1.61	$1.92
16	Infertility Diagnosis and Treatment	$2.40	$3.75	$1.06
17	Autism Spectrum Disorder Therapies *	$0.04	$0.74	$0.69
18	Coverage for Newborn Infants *	$6.03	$6.65	$7.06
19	Blood Lead Screening and Risk Assessment	$0.01	$0.01	$0.01
20	Preventive Pediatric (group only) *	$2.40	$2.65	$3.05
21	Low Protein Modified Food Products, Amino Acid Modified Preparations and Specialized Formulas	$0.29	$0.32	$0.34

	Mandate	2016 Projected Costs PMPM		
		Prior Report 5th year estimate (A)	Trended to 2016 (B = A * Trend)	Revised estimate (C)
22	Neuropsychological Testing for Children Diagnosed with Cancer	$0.00	$0.00	$0.00
23	Psychotropic Drug Availability *	$10.02	$11.57	$7.47
24	Mental Health or Nervous Conditions *	$10.33	$11.39	$31.82
25	Accidental Ingestion or Consumption of Controlled Drug	$0.04	$0.04	$0.03
26	Denial of Coverage Prohibited for Health Care Services to Persons with an Elevated Blood Alcohol Content	$0.04	$0.04	$0.28
27	Treatment of Medical Complications of Alcoholism (group only) *	$0.45	$0.50	$15.85
28	Occupational Therapy *	$1.05	$1.15	$0.21
29	Services of Physician Assistants and Certain Nurses	$0.00	$0.00	$0.00
30	Services Provided by the Veterans' Home	$0.40	$0.44	$0.00
31	Direct Access to OB/GYNs	$0.00	$0.00	$0.00
32	Chiropractic Services	$3.08	$3.39	$1.71
33	Experimental Treatments	$0.01	$0.00	$0.00
34	Off-label Use of Cancer, MS, Parkinson's Drugs	$3.31	$3.83	$5.76
35	Cancer Clinical Trials	$0.00	$0.00	$0.00
36	Hypodermic Needles and Syringes	$0.06	$0.07	$0.00
37	Prescription Drugs Removed from Formulary	$0.00	$0.03	$0.00
38	Home Health Care *	$1.70	$1.97	$0.19
39	Ambulance Services	$2.76	$3.04	$2.10
40	Prescription Drug Coverage/Mail-Order Pharmacies	$0.00	$0.00	$0.00
41	Co-payments Regarding In-Network Imaging Services	$1.22	$1.34	$1.36
42	Comprehensive Rehabilitation Services (mandatory offer) (group only) *	$2.94	$3.24	$0.82
43	Mobile Field Hospital	$0.00	$0.00	$0.00
44	Pain Management	$0.00	$0.00	$0.00
45	Maternity Benefits and Pregnancy Care Following Policy Termination (group only)	$0.00	$0.00	$0.00
46	Bone Marrow Testing	$0.00	$0.01	$0.01

*Denotes mandates with notable deviations from the prior PMPM cost estimate

B. Notable Deviations from Prior vs. Revised PMPM Cost Estimates were identified for select Mandates

Mandate 2: Prostate Cancer Screening and Treatment

- $0.25 prior PMPM vs $1.93 revised PMPM
- Prior estimate of $0.25 PMPM covered only screening for prostate cancer, but not the actual treatment. The 2010 estimated cost of $2.50 PMPM for prostate cancer treatment was not included since all carriers selling comprehensive health insurance or HMO benefits cover prostate cancer treatment as they do all accepted treatment for all other types of cancer.
- Revised estimates of $0.13 PMPM was for prostate cancer screening and $1.80 PMPM for treatment costs, totaling $1.93 PMPM.
- Prostate Cancer Treatment was included in the mandate starting Jan 1, 2012 (Connecticut Public Act 11-225, Sections 1 and 2).

Mandate 7: Diabetes Testing and Treatment

- $6.16 prior PMPM vs $10.25 revised PMPM
- Revised estimate includes $5.99 PMPM cost for prescription drugs. It is uncertain whether carriers included drug costs in the prior estimate.
- Differences in cost could be attributable to the following:
  - The mix of type-1 and type-2 diabetic patients within a given population will affect costs in either an increasing or decreasing manner.
  - Step-wise approach for treatment of type-2 diabetes. The older sulfonylureas and metformin are first line therapy. However, as the diabetes progresses, other agents are either added or substituted and many of these will be new, higher cost brand medications. If the disease progresses in the severity, the cost of treating these patients increases over time as newer or additional agents are used.
  - In type-1 diabetes where insulin or an insulin analogue is required, we have seen movement from the traditional Humulin and Novolin insulins to long acting products like Lantus combined with rapid acting insulins like Humalog and Novolog. These newer agents are more expensive than the older insulins.
  - Blood glucose testing supplies have not changed significantly except for new testing strips and more advanced glucose monitors which can be more expensive. The cost of insulin pumps is quite high and with new insulin pump technology, can lead to increased costs.

Mandate 11: Tumors and Leukemia

- $14.74 prior PMPM vs $36.72 revised PMPM

- Due to advances in medical technology from the initial study through 2013 data, there are now more advanced treatment options available, which may have led to a material increase in cost.

Mandate 12: Mammography and Breast Ultrasound

- $4.58 prior PMPM vs $2.70 revised PMPM
- Mammography mandate was first reviewed in the 2010 report with a 2010 cost estimate of $2.54 PMPM. In 2011, the mandate was expanded to cover MRIs for breast cancer screening. The prior paid PMPM was $0.92.
- Prior estimate assumed additional increase in utilization of 10% for MRIs and elimination of cost-sharing. This benefit was not actually adopted into law. We have reviewed historical experience from the past three years, and there has not been a material change in either the utilization or unit cost for MRIs.
- This mandate was amended to limit the copayment amount to $20 for breast ultrasounds, which will become effective January 1, 2015. Since Optum has been asked to calculate 2016 PMPM costs, we have incorporated this change into our assumptions.
- The revised estimate with the copayment limit was $2.70 PMPM, and the prior estimate was $4.58 PMPM.

Mandate 13: Maternity Minimum Stay

- $2.48 prior PMPM vs $1.00 revised PMPM
- The language of the mandate refers to the hospital stay following delivery, but does not refer to the cost of the delivery itself. In the prior study, the carrier data submitted included the cost of delivery.
- For the revised estimate, Optum pulled claims in excess of 48 hours for normal vaginal delivery and 96 hours for a caesarian section to estimate the cost of this mandate.

Mandate 17: Autism Spectrum Disorder Therapies

- $0.74 prior PMPM vs $0.69 revised PMPM
- The original PMPM estimate from the 2010 report of $0.04 PMPM reflects only the costs of the PT/OT/ST benefits. The mandate was expanded to provide coverage for behavioral therapy, psychiatry, or psychology because the carriers did not provide data to estimate those costs.
- The mandate was reviewed again in the 2012 report. The estimated PMPM 2016 costs were: $0.07 PMPM for extraterritoriality benefits, $0.16 PMPM for Developmental Relationship Based Therapy (DRBT), and $0.74 PMPM for the mandated benefits in 2010 (includes costs of behavioral therapy). Since the DRBT and extraterritoriality benefits were not adopted, they have not been included in the cost estimate.
- When the mandate was reviewed again in the 2012 report, the PMPM cost estimate was updated to include the cost of behavioral therapy. The 5th year projected cost from the 2012 report is what we have shown in the table (column B) because it is more up-to-

date and more accurate of a comparison to the benefits that were included in the revised PMPM costs. We did not apply trend to the $0.04 PMPM 2010 costs like the other mandates because the carriers did not provide claims for behavioral therapy services, which would understate the PMPM cost of the mandate.

- The revised PMPM estimate reflects the cost for OT/PT/ST and behavioral therapy.

Mandate 18: Coverage of Newborn Infants

- $6.65 prior PMPM vs $7.06 revised PMPM
- A newborn is defined in the mandate as a child from postpartum through the first 31 days of life. (Physicians sometimes use a 28 day definition.) It should exclude all delivery cost but include post-partum care and follow-up visits during the first 31 days.
- It will be skewed by expensive neo-natal cases for premature births. In the prior study, carriers had difficulty separating well newborn claims from other maternity, especially when the mother and baby reside in the same hospital room.
- This mandate was amended to provide coverage of newborn through the first 61 days of life, and became effective January 1, 2012. Prior PMPM costs were not updated to reflect this change. The cost through the first 31 days based on revised PMPM costs was $5.75, compared to the $6.65 prior PMPM cost.
- Based on the increased age from 31 to 61 days of life, the revised cost is $7.06 PMPM.

Mandate 20: Preventive Pediatric (group only)

- $2.65 Prior PMPM vs $3.05 revised PMPM
- This mandate applies to Group Only policies. The entire mandate requires coverage of both Pediatric Preventive Services in addition to blood lead screening and risk management (same benefits that are required in Mandate 19: Blood Lead Screening and Risk Management for Individual Only policies). The cost of blood lead screening itself is de minimis, but the cost of the preventive services for children is material.
- The PMPM cost for this mandate reflects only the cost for the Pediatric Preventive Services.

Mandate 23: Psychotropic Drug Availability

- $11.57 Prior PMPM vs $7.47 revised PMPM
- When the prior study was performed, SSRIs were peaking. Many of these drugs were expensive and highly utilized. Since then, many of these drugs are now available of a generic, which helped to reduce the cost of this mandate. In addition, many groups mandate the use of generic drugs, when available. Should the member still choose the more expense brand name drug, they would be responsible for the additional cost through their cost-sharing.
- Prior estimate assumed a trend rate of 7.5%.

Mandate 24: Mental Health or Nervous Conditions

- $11.39 prior PMPM vs $31.82 revised PMPM
- Drug cost of $17.23 PMPM is included in the revised PMPM estimate. In the prior report, only medical claims were included. Comparing medical only claims costs would be $11.39 for prior PMPM and $14.60 for revised PMPM costs.
- Costs may have increased more than trend due to the passage of Mental Health Parity regulations. Carriers were required to remove any dollar limits that applied to these benefits as well as any Essential Health Benefits (EHBs) that were covered in the plan. In response, many carriers converted their annual dollar limit amounts to a number of visits limit as a way to control costs.

Mandate 27: Treatment of Medical Complications of Alcoholism (group only)

- $0.50 prior PMPM vs $15.85 revised PMPM
- Drug cost of $13.66 PMPM is included in the revised PMPM estimate. In the prior report, only medical claims were included. Comparing medical only claims costs would be $0.50 for prior PMPM and $2.19 for revised PMPM costs.
- This mandate covers a broad range of diseases resulting from alcohol abuse. There was more PMPM cost variation than expected in the carrier data that was used to develop the prior estimate. The cost for this mandate could be easily skewed by a high cost claim, e.g. for a liver transplant.

Mandate 28: Occupation Therapy

- $1.15 prior PMPM vs. $0.21 revised PMPM
- In prior estimate, carriers may have included physical therapy (PT) and speech therapy (ST) costs, rather than only occupational therapy (OT). We did see a significant increase in paid PMPM costs when PT and ST claims were added.

Mandate 38: Home Health Care

- $1.97 prior PMPM vs $0.19 revised PMPM
- Home health services cross a range of provider types, and carriers submitted many different codes for this mandate. Prior estimate from carriers showed variations in cost and may be overstated.
- Insurers rely on home health to differing degrees to reduce the length of inpatient stays. Some insurers encourage early discharge by providing discharged patients with support in the home. This home health medical management strategy helps those carriers reduce the higher per day amount they spend on inpatient care.

Mandate 42: Comprehensive Outpatient Rehabilitation Services (group only)

- $3.24 prior PMPM vs $0.82 revised PMPM
- In prior estimate, it is possible that the carriers consistently overstated the cost of this mandate by employing a broad definition of the term CORF.

- This mandate requires coverage of these services on an outpatient basis only. In the prior estimate, the carriers' data included physical, speech, and occupational therapy claims, but it was unclear whether all of these services were performed on an outpatient basis only.
- The cost of this mandate includes costs that were already reported for the birth to three, occupational therapy, and autism spectrum disorder mandates.

C. Mandates with De Minimis (less than $0.05 PMPM) Cost

Mandate 1: Diabetes Self-Management Training

- This mandate provides training designed to educate diabetics on how to use their equipment and supplies to better self-manage their condition with training in self-care and nutrition.
- Disease Self-Management Training (DSMT) is inexpensive but cost-effective and highly desirable with respect to public health. Experts assert that savings result from diabetic disease management programs in general. However, these savings have not been estimated in our calculation, but are expected to exceed the cost by preventing costly premature complications of diabetes.

Mandate 4: Hearing Aids for Children Twelve and Under

- There are so few individuals utilizing the services covered under this mandate, that the cost is de minimis.

Mandate 6: Inpatient, Outpatient or One-day Dental Services

- This mandate requires health insurers to cover the facility, nursing, and anesthesia costs for those who need to have dental procedures performed in a hospital inpatient or outpatient setting under general anesthesia. All the dental costs are paid for under a separate dental policy or rider. Only the facility costs apply to the medical insurance.
- There are so few individuals utilizing the services covered under this mandate, that the cost is de minimis.

Mandate 8: Birth to Three Program

- This mandate was amended twice since Optum reviewed the PMPM costs:
    - The maximum benefit limit was increased from $3,200 to $6,400 per child per year and the aggregate benefit per child over the total three-year period was increased from $9,600 to $19,200.
    - New provisions related to coinsurance and a provision on benefit caps (group only): For a child with autism spectrum disorders, who is receiving early intervention services, the maximum benefit available through early intervention

providers shall be $50,000 per child per year and an aggregate benefit of $150,000 per child over the total three-year period.

- This mandate is intended to detect, diagnose, and treat children with developmental disabilities up to age three, at a cost of up to $6,400 per child per year. It provides developmental evaluations and early intervention services for infants and toddlers (from 0-36 months of age) who have significant developmental disabilities or a diagnosed medical condition such as Down syndrome, spina bifida, autism, blindness, deafness, or others that have a high probability of resulting in a developmental delay.
- Specific areas of development that are evaluated include:
    - cognitive development
    - physical development, including vision, hearing, motor and health
    - communication development
    - social or emotional development
    - adaptive skills development (known as self-help or daily living skills)
- Early intervention services may include: Assistive technology devices and services, Audiological services, Speech and language services, Family training and counseling, home visits, Health services necessary to benefit from other early intervention services, Medical services for Birth to Three diagnostic or evaluation purposes only, Nutrition services, Occupational therapy, Physical therapy, Psychological services, Service coordination, Special instruction, Social work services, Transportation or mileage reimbursement when necessary to receive other early intervention services, Vision and mobility services
- Services are usually delivered in settings that are natural for the child, including the family home, child care settings, and other places where children usually spend time. These services are described as habilitative (rather than rehabilitative) because normal function and skills have not yet been acquired.

<u>Mandate 14: Mastectomy or Lymph Node Dissection Minimum Stay</u>

- This is minimum stay mandate. However, in the prior study, it was interpreted by the carriers to include the full gross cost of mastectomy surgery as well as hospital stay.
- For the revised estimate, reflects only the cost of the inpatient stay in excess of 48 hours.

<u>Mandate 19: Blood Lead Screening and Risk Assessment</u>

- This mandate as written applies to individual plans only, but it is a component of Mandate 20: Preventive Pediatric, which applies to group plans only.
- The blood lead screening test itself is low cost and has low utilization. As a result, the cost is de minimis. This applies to the blood lead screening and risk assessment portion of Mandate 20 as well.

<u>Mandate 22: Neuropsychological Testing for Children Diagnosed with Cancer</u>

- This mandate requires coverage, without prior authorization, for neuropsychological testing of children diagnosed with cancer to assess developmental delay due to chemotherapy and radiation therapy.
- The paid cost for the testing and evaluation is rather low and utilization is also very low. As a result, the cost is de minimis.

Mandate 25: Accidental Ingestion or Consumption of Controlled Drug

- The cost of this mandate is de minimis because there are extremely few people and services affected by it.
- This mandate provides care for those who accidentally overdose on controlled drugs such as heroin or pharmaceuticals like Vicodin and other opiates used for pain medication.

Mandate 29: Services of Physician Assistants and Certain Nurses

- This mandate has not added any new cost to the healthcare system despite the fact that there may be additional primary care services performed.
- This extended base of PCPs allows patients to be treated earlier, which helps reduce the occurrence of downstream complications. Without these providers, there could actually be more specialty and inpatient care, which would add expense to the system.
- Most of the services performed by PAs and APRNs are also relatively low cost, such as office visits and various procedures performed during office visits. Physician Assistants and Nurse Practitioners improve the overall efficiency of the health care system, enhance availability of primary care, and thereby improve access.

Mandate 30: Services Provided by Veteran's Home

- Optum data did not show any claims incurred at a Veteran's Home.

Mandate 31: Direct Access to OB/GYNs

- This is more of a provider access mandate, which would not lead to additional PMPM costs
- It is our belief that no additional services are being provided or covered under this mandate. The same services are being performed just by a different provider.

Mandate 33: Experimental Treatments

- Since experimental treatments are not yet FDA approved, there can be no charge for them. The drug or device manufacturer must provide it to the patient for free under a "compassionate use" program.
- The only potential medical cost that could occur would be due to an adverse reaction to the experimental treatment or other side effect.
- Relatively few people obtain experimental treatments and, when they do, the cost of the treatment itself is free.

Mandate 35: Cancer Clinical Trials

- During a clinical trial, it is the sponsor that assumes responsibility for the cost of the trial treatment.
- The only cost that the patient's insurance may be asked to cover is that of 1) normal routine care, and 2) side-effects or adverse reactions. Under this mandate, the normal routine care during a trial is covered by insurers.

Mandate 36: Hypodermic Needles and Syringes

- Although the vast majority of drugs are taken orally, there are some drugs that may be administered by injection.
- Self-injectable drugs, as they are referred because they are administered outside a physician's office by the patient or a caregiver, are used to treat patients with diabetes, arthritis, hemophilia, multiple sclerosis, and other conditions.
- Only those who have been prescribed a self-injectable drug can receive a prescription for needles and syringes. Moreover, the patient must also have a prescription for a covered drug in order for the needles and syringes to be covered.
- The cost of a single syringe and needle is far less than the injected drug itself. As a result, the cost of this mandate is de minimis.

Mandate 37: Prescription Drugs Removed from Formulary

- There are several restrictive criteria that need to be met before this mandate is applicable to an individual, thus few people actually qualify to receive non-formulary drugs under this mandate. This mandate requires insurers to cover drugs that have been removed from their formulary if all of a restrictive set of conditions are satisfied.
- Optum believes the financial consideration of the formulary mandate to be immaterial (neutral) for the following reasons:
    - Given that the health plan is required to continue coverage of the drug, the health plan has the option of maintaining the drug on the formulary but do so by placing the drug into a higher copay tier. Most plans have moved from a closed formulary model to an open formulary model and use formulary tiers at various copay levels. In this instance, the drug will continue to be available to the member albeit at a higher copay. There is nothing in the legislation that requires the drug to be covered with the same copay or formulary tier. The higher copay may provide some savings to the plan and in other cases it may increase the financial obligations of the plan; it is dependent upon the copays of each tier and the cost of the target drug compared to the alternative.
    - If the plan has a closed formulary AND the drug is to be removed from the formulary, the health plan will "grandfather" existing members so that these members can continue to obtain the drug. Closed formularies, like open formularies, will often have a tiered formulary and the drug will simply move to

a higher copay tier. As stated above, the financial risk for the plan may increase or decrease.

- Generally when a drug moves to a high tier with a great member out-of-pocket share (copay), there is an incentive for the member to switch to an alternative drug with a lower copay. The alternative may also have a lower cost to the plan as well, such as when the target drug is a brand and the alternative is a generic. Although the members can continue to obtain the targeted drug, the members will often switch to an alternative that lowers their cost which may also be less costly to the health plan.
- In most cases newer drugs, especially those with better clinical outcomes, are more expensive. While the plan may "prefer" the newer drug by placing it at a "preferred" tier, the members may continue taking their previous drug therapies despite a lower copay for the newer drug. In these cases, the health plan will actually lower its pharmacy costs because the member is not switching to the new drug which has a higher cost.

- The effect of the legislation may increase or decrease the costs to the health plan depending on member behavior, drug costs, copay levels, and the pharmacy benefit structure. For that reason, Optum believes the overall financial risk to the plan is neutral. Plans have innovative strategies to mitigate the increased costs of such legislation by offering tiered formularies and varying the copays within those tiers from one year to the next.

Mandate 40: Prescription Drug Coverage/Mail-Order Pharmacies

- The cost of this mandate is de minimis because the drugs would get filled in either a retail pharmacy or mail-order pharmacy, and mail-order pharmacies are typically more cost effective.

Mandate 43: Mobile Field Hospital

- Mobile field hospital has never been deployed. In the event it is, it will help increase access to care during a temporary period of highly increased demand due to a catastrophic event. This event could be a natural disaster, pandemic, or some type of terrorist event. During such a period, one or more hospitals could become incapacitated, and the mobile hospital would provide a portable solution.
- To date, this mandate has not increased the cost of care in CT, and is thus considered de minimis.

Mandate 44: Pain Management

- There is no cost associated with the benefits covered under this mandate.
- This is merely a change in provider type, and not the additional costs due to expansion of benefits.

- While there is a cost associated with the office visits to such specialists and the medications they prescribe, no cost is reported here because this mandate simply permits the patient to receive care from the best type of provider for their condition.

Mandate 45: Continuation of Pregnancy Coverage in the Event of Termination of Insurance Coverage

- This mandate only affects insurers that withdraw from the state and thereby terminate all their group policies. In the event this occurs, the withdrawing insurer must continue to cover pregnant policyholders until six weeks after delivery.
- This mandate has also never been activated, so there is no cost associated with it.

IV. Mandates with Overlapping Benefits

Optum noted that the following mandates cover the same benefits. When appropriate, a recommendation for amendment is provided.

Mandate 1 – Diabetes Self-Management Training
Mandate 7 – Diabetes Testing and Treatments

- Mandate 7 language indicates that the mandate includes coverage of diabetes self-management training. This is a duplication of Mandate 1.
- Recommendation: Remove Mandate 1.

Mandate 8 – Birth to Three Program
Mandate 18 – Coverage for Newborn Infants

- There is overlap between Mandate 8 and 18.
- Recommendation: Insert language into Mandate 18 that indicates that it excludes "early intervention services provided as part of an individualized family service plan pursuant to section 17a-248e."

Mandate 8 – Birth to Three Program
Mandate 17 – Autism Spectrum Disorder Therapies

- There is overlap between Mandates 8 and 17.
- Recommendation: Insert language into Mandate 17 that indicates that it excludes "early intervention services provided as part of an individualized family service plan pursuant to section 17a-248e."

Mandate 23 – Psychotropic Drug Availability
Mandate 24 – Mental or Nervous Conditions

- There is overlap between Mandate 23 and 24.
- Recommendation: Revise language in Mandate 24 to exclude coverage for medications to eliminate the overlap.

Mandate 18 – Coverage for Newborn Infants
Mandate 21 – Low Protein Modified Food Products, Amino Acid Modified Preparation and Specialized Formulas

- There is an overlap between Mandates 18 and 21.
- Recommendation: Include language that excludes the coverage in Mandate 21 for the first 61 days of life.

Mandate 28 – Occupational Therapy
Mandate 32 – Chiropractic Services
Mandate 41 – Comprehensive Rehabilitation Services (mandatory offer) group only

- Recommendation: Exclude occupational therapy from Mandates 32 and 41.

Mandate 36 – Hypodermic Needles and Syringes
Mandate 7 – Diabetes Testing and Treatments

- There is overlap between Mandates 7 and 36.
- Recommendation: Exclude those with a diagnosis of diabetes from Mandate 36.

Mandate 30 – Services provided by the Veteran's Home

- Overlaps with many mandates.
- Recommendation: Include language in the Mandate that excludes services covered by other mandates.

Mandate 2 – Prostate Cancer Screening
Mandate 11 – Cancer, Tumor and Leukemia

- The new mandate on treatment of prostate cancer would seem to be subsumed by the broad language of Mandate 11 regarding the treatment of tumors.

V. COMMENTARY ON ADMINISTRATIVE COST

The premium dollar can be thought of as composed of three pieces.

- Medical Cost
- Administrative Cost
- Profit (or contribution to surplus for carriers that are not-for-profit)

Sometimes the term retention is used to mean the combined cost of administration and profit. The term "non-medical expense" means the same thing as retention. The cost of state premium tax is included in administrative cost; it is 1.75% of premium.

The cost of mandates is part of the overall cost of health care. As such, they come with an administrative cost. When mandates are introduced, they necessitate changes in various operational and technological processes, such as premium billing and claims payment systems. Health insurers need to configure benefit systems to handle the required benefit changes. They may also need to notify members or policy-holders of the changes and perhaps revise marketing and sales material. Even for a mandate whose medical cost is de minimis, there may still be an associated one-time administrative (admin) cost involved in implementation. Various functions within the insurance company need to be made aware of the change in minimum coverage, and there is an associated cost.

Separate from the one-time administrative cost is the ongoing administrative cost that occurs in subsequent years. This is the case for all the mandates in this report. Additional benefits come with additional claims processing and payment. Most health insurance companies, HMOs, and third party administrators have become adept with the operational aspects of benefit changes, although some systems and companies may accommodate change more easily. The systems modifications and ongoing operational costs associated with a benefit change may vary in complexity. Since all the mandates are ongoing, we estimated the administrative costs using a percentage of the medical cost. For the sake of simplicity, assume administrative cost including profit is 20% of every dollar of premium, and medical cost is 80%. In this case, retention would be 25% of medical (25% = 20% / 80%; or $1.25 total cost = $1 paid claims / (1 - $0.20 admin cost)).

Retention as a percent of premium varies from carrier to carrier and is different for group than for individual coverage. Companies may target a specific medical cost ratio (MCR = Claims / Premium), which varies by market segment. Typically, Individual business has an MCR of 80% while Group business has an MCR of 85%. Since retention is 1 – MCR, we can use the target MCR to estimate the administrative cost plus profit of the book of business.

In addition to administrative cost, insurers build a profit charge into their premiums in order to cover their cost of capital and assure their financial security. In the case of for-profit insurers, their profits also benefit their shareholders. We use the term retention to describe administrative cost plus profit, which is all non-medical cost.

On average, the portion of the health insurance premium dollar that is assumed to apply to administrative cost, including profit, is approximately as follows:

	Admin as Percentage of Total Premium	
	Range based on State of CT filings	Recommended Retention Charge
Individual	15% to 27%	24%
Small Group	14% to 23%	20%
Large Group	14% to 25%	17%

For simplicity's sake, 20% retention load to cover administrative costs and margin was applied to both Individual & Group business.

		2016 Projected Paid PMPM		
	Mandate	Medical Only PMPM	Retention Load PMPM	Medical & Retention PMPM
1	Diabetes Self-Management Training	$0.01	$0.00	$0.01
2	Prostate Cancer Screening	$1.93	$0.49	$2.42
3	Ostomy-Related Supplies	$0.10	$0.03	$0.13
4	Hearing Aids for Children Twelve and Under	$0.00	$0.00	$0.00
5	Craniofacial Disorders	$0.13	$0.04	$0.17
6	Inpatient, Outpatient or One-day Dental Services	$0.00	$0.00	$0.00
7	Diabetes Testing and Treatment	$10.25	$2.56	$12.81
8	Birth to Three Program	$0.04	$0.00	$0.05
9	Lyme Disease Treatments	$0.34	$0.08	$0.42
10	Colorectal Cancer Screening	$4.33	$1.08	$5.41
11	Tumors and Leukemia	$36.72	$9.18	$45.90
12	Mammography and Breast Ultrasound	$2.70	$0.68	$3.38
13	Maternity Minimum Stay	$1.00	$0.25	$1.25
14	Mastectomy or Lymph Node Dissection Minimum Stay	$0.01	$0.00	$0.01
15	Prescription Contraceptives	$1.92	$0.48	$2.40
16	Infertility Diagnosis and Treatment	$1.06	$0.26	$1.32
17	Autism Spectrum Disorder Therapies	$0.69	$0.17	$0.86
18	Coverage for Newborn Infants	$7.06	$1.77	$8.83
19	Blood Lead Screening and Risk Assessment	$0.01	$0.01	$0.02
20	Preventive Pediatric Care (group only)	$3.05	$0.75	$3.80
21	Low Protein Modified Food Products, Amino Acid Modified Preparations and Specialized Formulas	$0.34	$0.09	$0.43

		2016 Projected Paid PMPM		
	Mandate	Medical Only PMPM	Retention Load PMPM	Medical & Retention PMPM
22	Neuropsychological Testing for Children Diagnosed with Cancer	$0.00	$0.00	$0.00
23	Psychotropic Drug Availability	$7.47	$1.86	$9.33
24	Mental Health or Nervous Conditions	$31.82	$7.96	$39.78
25	Accidental Ingestion or Consumption of Controlled Drug	$0.03	$0.01	$0.04
26	Denial of Coverage Prohibited for Health Care Services to Persons with an Elevated Blood Alcohol Content	$0.28	$0.07	$0.35
27	Treatment of Medical Complications of Alcoholism (group only)	$15.85	$3.96	$19.81
28	Occupational Therapy	$0.21	$0.05	$0.26
29	Services of Physician Assistants and Certain Nurses	$0.00	$0.00	$0.00
30	Services Provided by the Veterans' Home	$0.00	$0.00	$0.00
31	Direct Access to OB/GYNs	$0.00	$0.00	$0.00
32	Chiropractic Services	$1.71	$0.42	$2.13
33	Experimental Treatments	$0.00	$0.00	$0.00
34	Off-label Use of Cancer, MS, Parkinson's Drugs	$5.76	$1.44	$7.20
35	Cancer Clinical Trials	$0.00	$0.00	$0.00
36	Hypodermic Needles and Syringes	$0.00	$0.00	$0.00
37	Prescription Drugs Removed from Formulary	$0.00	$0.00	$0.00
38	Home Health Care	$0.19	$0.05	$0.24
39	Ambulance Services	$2.10	$0.53	$2.63
40	Prescription Drug Coverage/Mail-Order Pharmacies	$0.00	$0.00	$0.00
41	Co-payments Regarding In-Network Imaging Services	$1.36	$0.34	$1.70
42	Comprehensive Rehabilitation Services (mandatory offer) group only	$0.82	$0.20	$1.02
43	Mobile Field Hospital	$0.00	$0.00	$0.00
44	Pain Management	$0.00	$0.00	$0.00
45	Maternity Benefits and Pregnancy Care Following Policy Termination	$0.00	$0.00	$0.00
46	Bone Marrow Testing	$0.01	$0.00	$0.01

VI. Appendix A – Description of Mandates

Descriptive Summary of Each Mandate

1. **Diabetic Self-Management Training (DSMT)**
   Anyone diagnosed with diabetes is eligible for three types of training of up to 10 hours for initial training, 4 hours for change in condition, and 4 hours change in technology. This training is intended to help diabetic people to help themselves better self-manage their diabetes, which covers education in proper use of equipment and supplies and nutrition therapy. (38a-492e and 38a-518e; Jan. 2000); initially reviewed 2010, Vol. I report

2. **Prostate Screening—PSA Test**
   Requires insurers to pay for PSA tests in accordance with standards established by the mandate. The frequency of testing is unspecified. (38a-492g and 38a-518g; Jan. 2000); initially reviewed 2010, Vol. I report

   2012: Prostate Cancer Treatment:
   In addition to diagnosis of prostate cancer for men meeting certain conditional criteria, which is required by the existing mandate, the 2012 mandate adds a requirement for treatment of prostate cancer. (SB 396 and PA 11-225); revised in 2012 report

3. **Ostomy Supplies**
   Requires insurers to cover up to $1,000 per year of medically necessary ostomy supplies for people with a colostomy, urostomy and ileostomy. Cannot be considered DME (Durable Medical Equipment) or be included with a DME annual maximum. (38a-492j and 38a-518j; Oct. 2000); initially reviewed 2009 and again 2010, Vol. I report

   Amendment effective January 1, 2012: Increased annual maximum benefit to $2,500.

   This mandate requires insurers to pay for up to $2,500 annually for ostomy supplies and appliances for ostomates with an ileostomy, colostomy, or urostomy. These three ostomies are used by patients in conjunction with the elimination of bodily waste. For these three different types of ostomates, their need for supplies and their consumption rates differ. Ostomy supplies and appliances consist primarily of either a one-piece pouch with attached wafer or two-piece pouch and separate wafer. There are also numerous ancillary supplies used in conjunction with these three ostomies, such as belts to hold the device in place. Ileostomates and urostomates consume supplies at a faster rate than colostomates. There may be individuals with both a urostomy and either a colostomy or ileostomy. Urostomies are not temporary. Ileostomies are rarely temporary.

4. **Hearing Aids**

Through age 12. Limit of $1,000 every two years will continue to be permitted—this is $1,000 in total, not per ear. Hearing aids shall be considered durable medical equipment (DME). (38a-490b and 38a-516b; Oct. 2001); initially reviewed 2010, Vol. I report

This mandate requires insurers to pay for hearing aids for children up to $1,000 every two years. Hearing devices usually cost more than $1,000 per ear – ranging from $500 for analog hearing aid as high as $5,000 for digital hearing aid – and as a result imposes a substantial cost-burden on the family of the insured. Children may outgrow them as their craniums grow. Thus they need to be replaced periodically. Most of this cranial growth occurs prior to the onset of puberty. Hearing loss in children is generally detected prior to the age of 13. There will be fewer new cases of hearing loss reported between 13 through 18 compared with 0 through 12. A much higher rate of hearing loss is reported in the elderly population. However, for a child, the reduction or loss of hearing can interfere with learning and social development. Under this mandate hearing aids may be considered durable medical equipment (DME). Thus, if there is a $1,000 annual limit on DME, the $1,000 maximum cost of the hearing aids may be included in it.

5. **Craniofacial Disorders**

Requires medical insurers to pay for orthodontic treatment for those with cleft palate. (38a-490c and 38a-516c; Oct. 2003); initially reviewed 2010, Vol. I report

The cost of orthodontic treatment may range from $1,000 to $10,000 depending on the amount of work required, and it may take place in phases over a time frame of several years. Some families have dental plans that cover orthodontia, so it is possible that their plans already pay for children with cleft palate.

6. **Inpatient, Outpatient, or One-Day Dental Services (Hospital Dental)**

Inpatient, outpatient, or one-day dental services for special populations requiring general anesthesia for dental work under certain conditions. (38a-491a and 38a-517a; Jan. 2000); initially reviewed 2010, Vol. I report

It requires health insurers to cover the facility, nursing, and anesthesia costs for those who need to have dental procedures performed in a hospital inpatient or outpatient setting under general anesthesia. All the dental costs are paid for under a separate dental policy or rider. Only the facility costs apply to the medical insurance. The medical cost of an individual hospital dental encounter may range from $4,000 to $10,000. The average cost of these services is about $8,000 for a 2 ½ hour operation under general anesthesia, and are typically reserved for those who cannot have dental treatment without general anesthesia.

7. Diabetes Testing and Treatment (Diabetes Equipment & Supplies)

Insurers must cover diagnosis and treatment of diabetes, including equipment, drugs, and supplies for people with diabetes. (38a-492d and 38a-518d; Oct. 1997); initially reviewed 2010, Vol. I report

Insurers may not apply higher cost-sharing to diabetes than other diseases or medical conditions. Implicit in the mandate is the requirement that the diabetes benefit be as rich as other medical benefits; insurers cannot apply separate limits to diabetes care or otherwise limit diabetes care relative to other benefits.

8. Birth to Three Program

Requires medically necessary early intervention habilitation services to $3,200 per year for three years. (38a-490a and 38a-516a; July 1996); initially reviewed 2010, Vol. I report

> **Amendment effective October 6, 2009:** ". . . and (2) a maximum benefit of $6,400 per child per year and an aggregate benefit of $19,200 per child over the total three-year period."
>
> **Amendment effective January 1, 2012:** New provisions related to coinsurance and a provision on benefit caps ***(group only):***
> ". . .for a child with autism spectrum disorders, who is receiving early intervention services, the maximum benefit available through early intervention providers shall be $50,000 per child per year and an aggregate benefit of $150,000 per child over the total three-year period."

This mandate covers habilitative services up to $6,400 per year for three years (birth to 3 years old) for detection, diagnosis, and treatment of autism and developmental disability. Whether these habilitative services should be paid by medical insurance has been debated, since they were not historically a traditional medical benefit in the same way that rehabilitative services are for those who have strokes, for example.

9. Lyme Disease

Requires coverage of not less than 30 days IV antibiotic treatment and or 60 days oral antibiotics. Further treatment is permitted based on recommendation of board-certified specialist. (38a-492h and 38a-518h; Jan 2000); initially reviewed 2010, Vol. I report

Lyme disease originated in CT, where it has a higher incidence rate than any other state. It is caused by the bite of a deer tick, which transmits spirochetal bacteria of the genus Borrelia. It is characterized by three stages, and the disease becomes more difficult to cure as time since

transmission increases. The remedy is antibiotics administered either intravenously or orally or both. The mandate covers 30 days of IV and 60 of oral antibiotics. More antibiotic treatment requires the prescription of certain board-certified specialists. Some practitioners believe that antibiotic use is required until no further symptoms remain. The CDC recommends that patients receive no more than 2 four-week courses of antibiotics.

When this mandate was passed in 2000, there were some doctors who believed that chronic Lyme disease should be treated with long-term antibiotics. Other doctors believed such a long term course of antibiotics would be injurious to the patient; and they argued that if the patient did not respond in some finite period of time, good medical practice dictated a search for a different diagnosis. Long term antibiotic therapy can carry significant risks and is recommended against by the Infectious Diseases Society of America. The mandate granted coverage of up to 30 days of intravenous and 60 days oral antibiotics administered by a doctor. A longer course of antibiotics, however, requires the recommendation of a board certified specialist.

10. Colorectal Cancer Screening

Requires annual fecal blood test or sigmoidoscopy, colonoscopy, radiologic imaging at frequency per age/family history standards established by American College of Gastroenterologists after consultation with the American Cancer Society. (38a-492k and 38a-518k; Oct 2001): initially reviewed in 2009 report and again in 2010, Vol. I report

This mandate requires insurers to cover fecal occult blood testing annually, and sigmoidoscopy, colonoscopy, and radiographic imaging periodically per standards established by the American College of Gastroenterology in consultation with the American Cancer Society. The primary cost is associated with the colonoscopy procedure, which is generally performed in an outpatient facility rather than in a physician's office. Colonoscopies have been thought of as preventive measure to colon cancer for those individuals with pre-cancerous intestinal polyps that are removed during the procedure thereby preventing the polyp from growing into a cancerous tumor.

11. Cancer, Tumors, Leukemia, etc.

Requires coverage of the same plus reconstructive surgery, prosthesis, chemotherapy, wigs, and breast reconstruction after mastectomy. Certain limits apply. (38a-504 and 38a-542; July 1994); initially reviewed 2010, Vol. I report

This mandate is broader than the others and covers several aspects of cancer aggregated into one mandate. The treatment of tumors and leukemia, radiation therapy and chemotherapy for cancer treatment, reconstructive surgery, implantable prostheses, wigs for those who lose their hair during chemotherapy, and removal of breast implants obtained prior to 1994 are all covered under this mandate.

12. **Mammography and Breast Ultrasound**

Requires coverage of a minimum of baseline mammogram for women 35 to 39 and annual mammogram for those age 40 and older. Additional conditional benefit of comprehensive ultrasound screening. (38a-503 and 38a-530; Oct 2001); initially reviewed 2010, Vol. II report

2011: MRI for Breast Cancer Screening under Certain Conditions

Requires coverage of MRI (magnetic resonance imaging) as a supplement to mammogram and ultrasound for breast cancer screening for women meeting specified conditions including family history of breast cancer and presence of dense breast tissue. Revised estimate in 2011 report

This mandate applies only to women who meet certain conditions that increase either their likelihood of developing breast cancer or the possibility that it may not be detected by mammograms and ultrasound. An example of one of these conditions is family history of breast cancer or presence of the BRCA 1 or BRCA 2 gene; another is the presence of dense breast tissue. Most women will not meet these extended criteria. The rules for applying the criteria are not clearly black and white and rely on physician judgment.

Amendment effective January 1, 2015: Limits copayments for breast ultrasounds to 20 dollars.

13. **Maternity Care, Minimum Stay**

Requires insurers to cover a minimum of a 48 hour stay following normal delivery and 96 hours after caesarean. Earlier discharge is possible with consent of patient and attending physician subject to follow-up visit (38a-503c and 38a-530c; Oct. 1996); initially reviewed 2010, Vol. II report

This is also a federal mandate.

14. **Mastectomy Care, Minimum Stay**

Requires insurers to cover a minimum of 48 following mastectomy or lymph node dissection, and longer stay if physician recommends and patient consents. Earlier discharge is possible with consent of patient and attending physician. (38a-503d and 38a-530d; July 1997); initially reviewed 2010, Vol. II report

15. Prescription Contraception

Policies that include outpatient prescription drugs cannot exclude prescription contraception. (38a-503e and 38a-530e; Oct. 1999); initially reviewed 2010, Vol. II report

Requires coverage of prescription contraception in outpatient prescription drug plans, unless the group or individual declines for stated religious reasons. By making this benefit available in virtually all prescription drug policies, the availability of contraception drugs was expanded in the fully insured population. The vast majority of prescription contraception drugs are obtained through a pharmacy.

16. Infertility Diagnosis and Treatment

Requires coverage for diagnosis and treatment of infertility subject to conditions and limitations. Covers up to two cycles of in vitro fertilization or transfer and a maximum of two embryo implants per cycle. (38a-509 and 38a-536; Oct. 2005); initially reviewed 2010, Vol. II report

There are two primary methods—intrauterine insemination and in vitro fertilization.

Infertility refers to an inability to conceive after having regular unprotected sex. Infertility can also refer to the biological inability of an individual to contribute to conception. In many countries infertility refers to a couple that has failed to conceive after 12 months of regular sexual intercourse without the use of contraception.

Women are covered by the mandate until age 40. Four cycles of ovulation induction are permitted. Three attempts are permitted for intrauterine insemination and up to two cycles of in vitro fertilization or transfer with no more than two embryo implantations per cycle. The number of embryos is a controversial area.

17. Autism Spectrum Disorders

Requires medical insurers to cover physical, speech, and occupational therapy (PT/OT/ST) for the treatment of autism spectrum disorders (ASD) to the same extent as coverage for other diseases. If the policy does not cover PT/OT/ST for other diseases and conditions, then it is not required to cover it for ASD. (38a-488b and 38a-514b; Jan. 2009); initially reviewed 2010, Vol. II report

ASD is a congenital developmental disorder characterized by problems in three areas: social development, communication and stereotypic behaviors. It encompasses a number of disorders including Autism, Retts Syndrome, Childhood Disintegrative Disorder and Asperger's Syndrome. ASD can vary in severity. Government statistics suggest the prevalence rate of autism is increasing annually. There is no clear explanation for this, but two reasons cited are improved

diagnosis and environmental influences. Studies suggest boys are more likely than girls to develop autism and receive the diagnosis three to four times more frequently. This mandate does not cover behavioral therapy, but a revised version that took effect in Jan 2010 does. The utilization rates for behavioral therapy for ASD may be five to ten times greater than the combined rates for PT/OT/ST.

Physical, occupational, and speech therapies (PT/OT/ST) for the treatment of autism spectrum disorders (ASD) are reputed to be helpful for children with ASD because they address their problems with communication, physical control, and social development. Children with autism not only have communication difficulties but also problems with social interaction that stem from their frustration with their inability to communicate. There are many types of speech therapy. Some may use picture symbol communication for those children with minimal speech skills. Speech therapy may address behavior and actions. Speech and occupational therapy are utilized more often than physical therapy.

Children with ASD often have issues with gross and fine motor skills that interfere with basic day-to-day functioning as well as development both social and physical. Physical therapists may work with children and their parents to teach the child mobility and motor skills. Young children may receive assistance to help them learn how to sit, roll, stand, and play. Occupational therapists are trained to evaluate whether children are able to carry out activities expected at their age. They also treat children with ASD and promote self-help skills that will help with independent living. Services of therapists are often billed in 15 minute intervals that cost $30 to $58.

This mandate originally became law in Jan 2009. In Jan 2010, a revised and stronger version of this mandate went into effect that also covers behavioral therapies.

2012: Autism Spectrum Disorder (ASD) – *(Group Only)*

a. In the context of reviewing the two ASD mandates above, the current ASD mandate, 38a-514b, was reviewed along with two mandates that were not adopted (Developmental Relationship-Based Therapy and Extraterritorial Application). Like SB 974 and SB 978, the current ASD mandate applies to Group only.

18. **Newborn Infants**

Requires coverage of newborn infants from the moment of birth. Newborn care includes all post-partum care through the first 31 days of life. No pre-existing condition may be applied to newborns. Newborns may not be refused insurance coverage. (38a-490 and 38a-516; Oct. 1974); initially reviewed 2010, Vol. II report

Amendment effective January 1, 2012: "… service corporation, medical service corporation or health care center not later than sixty-one days after the date of birth in order to continue coverage beyond such sixty one-day period".

19. Blood Lead Screening and Risk Assessment

(Individual Only): Individual insurers must cover blood lead screening and risk assessments ordered by a primary care provider. (38a-490d; Oct. 1997); initially reviewed 2010, Vol. II report

Lead screening blood test itself is low cost—it runs about $12 - $52 for an 83655 test. The vast majority of claims are for CPT code 83655, which is a blood test specifically to test for lead. For a child who tests positive, there are two additional codes for tests to measure whether the blood lead level is decreasing— 84202 and 84203. These latter two codes can also be used to determine whether there is new exposure. Their cost may be somewhat greater than the cost of an 83655. The cost of treating a child with a severe case of lead poisoning can be very high and involve inpatient care. It applies to individual plans only, but it is a component of the following mandate (#20), Preventive Pediatric Care and Blood Lead Screening, that applies to group only.

20. Preventive Pediatric Care and Blood Lead Screening

(Group Only): Requires group plans to cover the same lead screening and risk assessment as individual policies, as of Jan 2009. Also requires group coverage of pediatric preventive services, which include the review of a child's health from birth through six years of age by a primary care physician per schedule. (38a-535; Oct 1990); initially reviewed 2010, Vol. II report

Such review shall include medical history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards. Preventive care is the far more costly aspect of this mandate. Preventive care includes well child visits per a mandated schedule; it also includes immunizations. The schedule is approximately every two months for birth to six months, every three months from nine to eighteen months, and annually from two through six years of age.

These well-child office visits involve screening tools to detect and diagnose autism and developmental delay. The visit is about 30 minutes. Physicians provide parents with anticipatory guidance to help them understand their child's development and medical needs.

The cost of an office visit for a new patient that is 1 to 4 years old is about $155. The cost of a return visit is about $135. The estimated total allowed cost of immunizations for a child is about $600 in the first year of life and about double that for all immunizations from birth through adolescence.

21. Low Protein Modified Food Products, Amino Acid Modified Preparations and Specialized Formulas (Prescription Food)

Requires coverage of specific preparations and food products for the treatment of inherited metabolic diseases if prescribed and under the direction of a physician. (38a-492c and 38a-518c; Oct. 1997). A revision in Oct. 2007 modified the mandate to no longer include the requirement that the specialized food be prescribed, only that it be administered under the direction of a physician. Initially reviewed 2010, Vol. II report

The mandate protects those individuals who are born with rare disorders that prevent them from enjoying a normal diet. There is an FDA definition of "medical food." It is "prescribed by a physician when a patient has special nutrient needs in order to manage a disease or health condition, and the patient is under the physician's ongoing care. The label must clearly state that the product is intended to be used to manage a disease or health condition, and the patient is undergoing the physician's ongoing care." The FDA further excludes certain categories of foods from the definition such as low sodium, reduced fat, and weight loss products. One oft-cited example of medical food is food free of the amino acid phenylalanine, which cannot be processed by those with phenylketonuria.

There are three categories of special food covered by the mandate:

- Low protein modified food products
- Amino acid modified preparations, and
- Specialized formula

The dosing for these foods is 3 to 4 times daily. Their manufacture requires sterile conditions. Much of the cost of this mandate was for patients (usually babies but also young children) that are born with or develop extreme allergies to food.

22. Neuropsychological Testing for Children with Cancer (Developmental Needs of Children with Cancer)

Requires coverage, without prior authorization, for neuropsychological testing of children diagnosed with cancer to assess developmental delay due to chemotherapy and radiation. (38a-492l and 38a-516d; Oct 2006); initially reviewed 2010, Vol. II report

Managed care organizations are not permitted to require a gatekeeper to approve this testing, nor is any other form of prior authorization allowed. The removal of a prior authorization requirement allows the insured patient's family to access neuropsychological testing services without any managed care impediment.

23. Availability of Psychotropic Drugs in Health Plans

Prohibits mental health benefits from limiting the availability of the most therapeutically effective psychotropic drugs or requiring the utilization of those that are not the most therapeutically effective. Neither differential copays nor utilization review is prohibited by this mandate. (38a-476b; Oct. 2001); initially reviewed 2010, Vol. III report

The cost of this mandate is increasing over time as new drugs are developed and direct-to-consumer advertising increases the demand for them; the rate of increase has been greater for psychotropic than for the rest of medical and pharmaceutical spending. In part, this reflects the development and availability of new drugs and the rapid evolution of classes such as SSRIs and SNRIs (selective serotonin reuptake inhibitors and serotonin norepinephrine reuptake inhibitors). Some of these drugs are taken on a long-term, maintenance basis; others may be short-term and situational.

24. Mental Health or Nervous Conditions

Requires insurers to cover diagnosis and treatment of defined mental and nervous conditions. Included in the definition of these conditions are mental health and substance abuse (MH/SA) diagnosis and treatment. Per the mandate, "Mental or Nervous Conditions" means mental disorders as defined in the most current edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders." Mental health and substance abuse benefits must be offered at parity with other medical benefits. This mandate lists the types of providers authorized to provide services in addition to licensed physicians and psychologists. Services are covered on an inpatient or outpatient basis in a variety of medical settings. Not all of the providers of MH/SA services are licensed to prescribe medications, but this mandate makes no reference to medication. It refers only to the services of mental health providers. (Medications for mental and nervous conditions are covered under the psychotropic drug mandate.) This MH/SA mandate is the latest iteration of a mental health mandate that first took effect in CT in 1971. It supersedes the prior mandate on biologically-based mental illness, section 38a- 514a. (38a-488a and 38a-514; Jan. 2000); initially reviewed 2010, Vol. III report

25. Accidental Ingestion of Controlled Substance

Requires insurers to cover the expenses of emergency medical care arising from accidental ingestion or consumption of a controlled drug. Inpatient coverage shall be covered for at least 30 days in a calendar year. Up to at least $500 of non-inpatient care shall also be covered. (38a-492 and 38a-518; July 1975); initially reviewed 2010, Vol. III report

26. Prohibition from Denying Coverage Based on Intoxication (Health Services for People with Elevated Level of Alcohol in Blood)

Prevents insurers from denying coverage for services rendered to treat any injury sustained by any person with elevated blood alcohol level (.08% or more) or under the influence of

intoxicating liquor or any drug or both. (38a-498c and 38a-525c; Oct. 2006); initially reviewed 2010, Vol. III report

27. **Coverage for Treatment of Medical Complications of Alcoholism**

(Group only) Requires coverage for the diagnosis and treatment of medical complications of alcohol including diseases such as cirrhosis of the liver, gastrointestinal bleeding, pneumonia, and delirium tremens, and thus requires coverage of detoxification. (38a-533; Jan. 2000); initially reviewed 2010, Vol. III report

28. **Coverage for Occupational Therapy (OT)**

Requires medical insurers to cover OT provided by a licensed occupational therapist in accordance with a plan of care established in writing by a licensed physician. Physician must certify that the prescribed care and treatment are unavailable from other provider types and are provided in private practice or a licensed health care facility. Physician must review and certify the treatment plan at least every two months. This older mandate went into effect at a time when not all medical plans covered therapy services. (38a-496 and 38a-524; Oct. 1982); initially reviewed 2010, Vol. III report

29. **Mandatory Coverage for Physician Assistants and Certain Nurses**

This mandate defines three categories of nurses--certified nurse practitioner, certified psychiatric-mental health clinical nurse specialist, and certified nurse-midwife; and it defines physician assistant. Insurance policies shall provide coverage for the services of these licensed independent providers as long as they are within their area of competence and currently reimbursed when rendered by other licensed providers. They were referred to as "mid-level" providers before the term fell into disuse. The mandate does not permit RNs or physician assistants to provide services beyond their scope of practice. (38a-499 and 38a-526; Oct. 1984); initially reviewed 2010, Vol. III report

30. **Mandatory Coverage for Services Provided by the Veteran's Home**

Insurers must cover service provided by the Veteran's Home, which is located on West Street in Rocky Hill, CT. This mandate came into being at the time this institution changed its name. (38a-502 and 38a-529; Oct. 1988); initially reviewed 2010, Vol. III report

31. **Permit Direct Access to OB/GYNs**

Requires gatekeeper health insurance plans to permit female members to see their obstetrician/gynecologist without a referral. Non-gatekeeper plans are unaffected because they

have never required their members to have a referral from their primary care physician in order to visit a specialist. This effectively enables OB/GYNs in gatekeeper plans to function as primary care physicians for their female patients. (38a-503b and 38a-530b; Oct. 1995); initially reviewed 2010, Vol. III report

32. Mandatory Coverage for Chiropractic Services

Requires insurers to provide coverage for services rendered by licensed chiropractors to the same extent as those rendered by physicians as long as the service is covered under the policy and is within the scope of services the chiropractor is licensed to perform. (38a-507 and 38a-534; Oct 1989); initially reviewed 2010, Vol. III report

33. Experimental Treatments

Prohibits insurers from denying a procedure, treatment, or drug that has completed a phase three trial of the Food and Drug Administration (FDA) but has not yet been approved by the FDA for widespread distribution. Those with life expectancy of less than two years who have been denied a procedure, treatment, or drug because it is experimental, may request an expedited appeal. The reviewers shall consider whether its use has been approved by one of two medical organizations or is listed in any of several specified drug compendia, or is currently in a phase three clinical trial of the FDA. (38a-483c and 38a-513b; Jan. 2000); initially reviewed 2010, Vol. IV report

34. Coverage for Off-Label Use of Cancer Drugs

Prohibits insurers that provide coverage for prescribed drugs approved by the federal Food and Drug Administration for treatment of certain types of cancer from excluding coverage of any such drug on the basis that it has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: (1) The U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional (USP DI); (2) The American Medical Association's Drug Evaluations (AMA DE); or (3) The American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI).

This mandate does not require coverage for any drug which the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed. It also does not affect reimbursement for drugs used in the treatment of any other disease or condition. (38a-492b and 38a-518b; Oct. 1994); initially reviewed 2010, Vol. IV report

2011: Coverage for Off-Label Multiple Sclerosis (MS)/Parkinson Disease

Provides coverage for prescribed drugs approved by the federal Food and Drug Administration for treatment of certain types of cancer or disabling or life-threatening chronic diseases (11-172, s. 15, 16 Jan. 2012); reviewed again in 2011 report

35. **Cancer Clinical Trials**

Requires insurers to provide coverage for the routine patient care costs associated with cancer clinical trials. "Cancer clinical trial" means 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, except that a clinical trial for the prevention of cancer is eligible for coverage only if it involves a therapeutic intervention and is a phase III clinical trial approved by one of the four entities identified in section b of the mandate and is conducted at multiple institutions. Routine patient care is also defined in the mandate in terms of what is included and what is not. For example, the mandate excludes from routine patient care the cost of transportation, lodging, food or any other expenses associated with travel to or from a facility providing the cancer clinical trial, for the insured person or any family member or companion. Routine care includes all the items and services that are generally available to the insured. This includes whatever is typically covered absent the trial. It includes whatever may be needed to provide the investigational item or service, such as administration of an experimental chemotherapeutic agent, clinically appropriate monitoring of the experimental item or service, and whatever is needed for prevention of complications. It includes whatever is needed for the diagnosis and treatment of complications. (38a-504a - g and 38a-542a - g; Jan 2002); initially reviewed 2010, Vol. IV report

36. **Mandatory Coverage for Hypodermic Needles and Syringes**

Requires insurers to cover these items when prescribed by a provider for self-injected medication that is also covered by the policy. The same policy terms apply to these items as other benefits. (38a-492a and 38a-518a; July 1992); initially reviewed 2010, Vol. IV report

37. **Prescription Drugs Removed from Formulary**

Prohibits insurers from denying coverage for a drug that is not or is no longer on the insurer's list of covered drugs when three conditions apply: 1) insured was using the drug prior to cessation of that drug's coverage, 2) insured was covered under the policy for that drug prior to cessation of that drug's coverage, and 3) insured's attending provider states in writing that it is medically necessary and lists reasons why it is more beneficial than the drugs remaining on the insurer's list of covered drugs. The same policy terms apply to these drugs as other covered drugs. (38a-492f and 38a-518f; Jan. 2000); initially reviewed 2010, Vol. IV report

38. **Home Health Care**

Requires insurers to provide coverage for home health care to CT residents in lieu of continued hospitalization according to a written physician plan under stated conditions, such as within 7 days of discharge. Home care must be provided by a duly licensed federally certified agency meeting five specified criteria. The mandate defines home health care to include RN and LPN nursing, home health aides, PT/OT/ST, social services, and prescribed drugs, supplies, and medication. (38a-493 and 38a-520; Oct. 1975); initially reviewed 2010, Vol. IV report

39. Ambulance Services

Requires coverage for medically necessary ambulance transportation to a hospital subject to a maximum allowable rate established by the Department of Health subject to the same policy terms as other benefits. Establishes that the hospital insurance policy is primary in the event the person is covered by more than one policy. Also states that payment shall be made directly to the ambulance provider as long as that provider complies with subsection provisions and has not received payment from another source. (38a-498 and 38a-525; Mar 1984 / revised Oct 2002); initially reviewed 2010, Vol. IV report

40. Prescription Drug Mail-Order Prohibition

Prohibits health insurance policies that cover prescription drugs from requiring that drugs be obtained from a mail order source as a condition for obtaining any drug. Does not prohibit the use of mail order drug filling. (38a-510 and 38a-544; Jul. 1989 Group / Jul. 2005 Individual); initially reviewed 2010, Vol. IV report

41. Copayments Regarding In-Network Imaging Services

Copayments for In-Network Services: Applies only to complex medical imaging—magnetic resonance imaging (MRI), computed axial tomography (CAT) scans, and positron emission tomography (PET) scans. Applies only to in-network services. Prohibits insurers from charging one person more than $375 annually in aggregate copayments for all in-network MRI and CAT Scans, and prohibits charging more than $75 for any single in-network MRI or CAT scan. Also prohibits insurers from charging one person more than $400 annually in aggregate copayments for all in-network PET scans, and prohibits charging more than $100 for any single in-network PET scan. The copay limits are set and do not adjust for inflation over time. This mandate does NOT apply to high deductible plans. Stipulates that, in order for the copayment limit to apply, the physician ordering the scan is not the same person as the physician providing it or participating in the same group practice. (38a-511 and 38a-550; May 2007); initially reviewed 2010, Vol. IV report

All CT, MRI, PET scans involve two components to the fee—1) a technical facility component for capturing the image, and 2) a professional fee for reading the image and interpreting the results. PET scans also involve a fee for the use of a radioactive pharmaceutical. Some MRIs and CT

scans may involve the use of a dye that increases the cost. On average, ultrasound treatment costs less than a CT scan, which costs less than a MRI, which costs less than a PET scan. CT scans may range from about $1,200 to $3,200 depending on location and type. MRI may be $1,200 to $4,000, and PET scans $3,000 to $7,000. These are the all-inclusive allowed costs of these services, some of which is paid by the patient in the form of cost sharing; the rest is paid by the insurer.

42. Offer of Coverage for Comprehensive Outpatient Rehabilitation Services (CORF)

(Group only) Insurers must offer groups the opportunity to purchase a plan that includes coverage of comprehensive rehabilitation services as defined by the mandate. These must be provided in an accredited outpatient facility. Services include PT/OT/ST, physician, psychological, social services performed by a social worker, respiratory therapy, drugs and medication, prosthetics and orthotics, and other supplies and services prescribed by a physician for the rehabilitation of the patient. Unlike most of the mandates, which are required to be covered in all insurance plans, the tenth mandate is not. The insurer is required to offer a policy that covers it, but the group buyer can choose whether it wants a policy with such coverage. Insurers may include these CORF services in all their policies. (38a- 523; latest revision in 1991); initially reviewed 2010, Vol. IV report

43. Mobile Field Hospital

This mandate has never been activated because the mobile field hospital has never been deployed. The mobile field hospital is a public health program that provides onsite care in the event of a natural disaster or other such catastrophic occurrence. This mandate stipulates that medical care provided by the mobile field hospital should also be covered by insurance. It also says that insurers will reimburse providers at Medicaid rates. "The rates paid by group health insurance policies pursuant to this section shall be equal to the rates paid under the Medicaid program, as determined by the Department of Social Services." Medicaid rates can be lower than commercial payments by 20% to 50%. (38a-498b and 38a-525b; July 2005); initially reviewed 2010, Vol. IV report

44. Pain Management

Requires access to a pain management specialist and coverage for pain treatment. Insurers cannot require people to receive pain management services only from their primary care physician. The mandate defines "pain" and "pain management specialist." It does not include non-physicians in the definition of pain management specialist. This mandate applies to acute care as well as chronic care. New pain interventions such as pain pumps and epidural pain management would also be covered. (38a-429i and 38a-518i; Jan. 2001); initially reviewed 2010, Vol. IV report

Amendment effective January 1, 2012: Limits ability of carriers to require use of over-the-counter and other alterative drugs before covering prescription drugs in some cases.

Amendment effective June 15, 2012: Added "physiatrist" to definition of "pain management specialist".

45. **Continuation of Pregnancy Coverage in the Event of Termination of Insurance Coverage *(Group Only)*** This mandate has not been activated because no carrier has withdrawn from the state and terminated all its insurance coverage in CT. This mandate only affects insurers that withdraw from the state and thereby terminate all their group policies. In the event this occurs, the withdrawing insurer must continue to cover pregnant policyholders until six weeks after delivery. (38a-547); initially reviewed 2010, Vol. IV report

46. **Bone Marrow Testing**

This benefit became effective January 1, 2012. It has not been retrospectively reviewed. Identical language was prospectively reviewed in 2009. **(**38a-492o / 518o); initially reviewed 2009 report

2009: HLA (Human or Histocompatibility Leukocyte Antigen) Test: New mandate. Potential bone marrow donor's policy must cover the cost of initial HLA testing, plus "costs arising from it," such as subsequent site infection that might occur in very rare instances. Individual must register as donor with National Bone Marrow transplant registry. The HLA test covered is the initial screening of six loci—A, B, and DR antigens. Our interpretation is that this mandate is intended to encourage unrelated potential donors to sign up for the registry. It does not cover the subsequent cost of compatibility testing for loci C, DQ, or DP, or confirmatory testing, which is paid by the insurer of the patient recipient.

HLA testing consists of initial screening and secondary compatibility and confirmatory testing. Essentially, there are three aspects to the medical cost increase:

- Increased initial HLA testing,
- Increased post-initial compatibility and confirmatory HLA testing, and
- Increased bone marrow transplants (BMT) performed. There are only a few allogeneic BMTs performed annually in the US at a cost of $150,000 to $200,000 each. Allogeneic BMTs involve a donor other than the patient/recipient. Autologous BMTs use the patient's own bone marrow or stem cells.

VII. Appendix B – Additional Tables

A. Table 1

The table below shows a side by side comparison of the PMPM costs between the prior PMPM estimates from the initial year of review (i.e. not the 5th year projected cost) compared to the 2016 revised PMPM estimate. The 1st and 3rd columns are the paid claims cost estimates. The 2nd and 4th columns are the total cost estimates that include the 20% retention assumption.

Paid Costs:

		Prior PMPM		2016 Revised PMPM	
	Mandate	Paid Cost	Total Cost (include retention load)	Paid Cost	Total Cost (include retention load)
1	Diabetes Self-Management Training	$0.06	$0.07	$0.01	$0.01
2	Prostate Cancer Screening	$0.19	$0.23	$1.93	$2.42
3	Ostomy-Related Supplies	$0.06	$0.07	$0.10	$0.13
4	Hearing Aids for Children Twelve and Under	$0.01	$0.01	$0.00	$0.00
5	Craniofacial Disorders	$0.02	$0.02	$0.13	$0.17
6	Inpatient, Outpatient or One-day Dental Services	$0.05	$0.06	$0.00	$0.00
7	Diabetes Testing and Treatment	$4.60	$5.52	$10.25	$12.81
8	Birth to Three Program	$0.22	$0.26	$0.04	$0.05
9	Lyme Disease Treatments	$0.28	$0.34	$0.34	$0.42
10	Colorectal Cancer Screening	$3.40	$4.08	$4.33	$5.41
11	Tumors and Leukemia	$11.00	$13.20	$36.72	$45.90
12	Mammography and Breast Ultrasound	$3.46	$4.15	$2.70	$3.38
13	Maternity Minimum Stay	$1.85	$2.22	$1.00	$1.25
14	Mastectomy or Lymph Node Dissection Minimum Stay	$0.10	$0.12	$0.01	$0.01
15	Prescription Contraceptives	$1.20	$1.44	$1.92	$2.40
16	Infertility Diagnosis and Treatment	$2.80	$3.36	$1.06	$1.32
17	Autism Spectrum Disorder Therapies	$0.03	$0.03	$0.69	$0.86
18	Coverage for Newborn Infants	$4.96	$5.95	$7.06	$8.83
19	Blood Lead Screening and Risk Assessment	$0.01	$0.01	$0.01	$0.02
20	Preventive Pediatric Care (group only)	$1.91	$2.29	$3.05	$3.80
21	Low Protein Modified Food Products, Amino Acid Modified Preparations and Specialized Formulas	$0.24	$0.29	$0.34	$0.43
22	Neuropsychological Testing for Children Diagnosed with Cancer	$0.00	$0.00	$0.00	$0.00
23	Psychotropic Drug Availability	$7.50	$9.00	$7.47	$9.33

	Mandate	Prior PMPM Paid Cost	Prior PMPM Total Cost (include retention load)	2016 Revised PMPM Paid Cost	2016 Revised PMPM Total Cost (include retention load)
24	Mental Health or Nervous Conditions	$8.50	$10.20	$31.82	$39.78
25	Accidental Ingestion or Consumption of Controlled Drug	$0.03	$0.04	$0.03	$0.04
26	Denial of Coverage Prohibited for Health Care Services to Persons with an Elevated Blood Alcohol Content	$0.03	$0.04	$0.28	$0.35
27	Treatment of Medical Complications of Alcoholism (group only)	$0.37	$0.44	$15.85	$19.81
28	Occupational Therapy	$0.86	$1.03	$0.21	$0.26
29	Services of Physician Assistants and Certain Nurses	$0.00	$0.00	$0.00	$0.00
30	Services Provided by the Veterans' Home	$0.33	$0.40	$0.00	$0.00
31	Direct Access to OB/GYNs	$0.00	$0.00	$0.00	$0.00
32	Chiropractic Services	$2.53	$3.04	$1.71	$2.13
33	Experimental Treatments	$0.00	$0.00	$0.00	$0.00
34	Off-label Use of Cancer, MS, Parkinson's Drugs	$2.86	$3.43	$5.76	$7.20
35	Cancer Clinical Trials	$0.00	$0.00	$0.00	$0.00
36	Hypodermic Needles and Syringes	$0.05	$0.06	$0.00	$0.00
37	Prescription Drugs Removed from Formulary	$0.02	$0.02	$0.00	$0.00
38	Home Health Care	$1.47	$1.76	$0.19	$0.24
39	Ambulance Services	$2.27	$2.73	$2.10	$2.63
40	Prescription Drug Coverage/Mail-Order Pharmacies	$0.00	$0.00	$0.00	$0.00
41	Co-payments Regarding In-Network Imaging Services	$1.00	$1.20	$1.36	$1.70
42	Comprehensive Rehabilitation Services (mandatory offer group only)	$2.42	$2.90	$0.82	$1.02
43	Mobile Field Hospital	$0.00	$0.00	$0.00	$0.00
44	Pain Management	$0.00	$0.00	$0.00	$0.00
45	Maternity Benefits and Pregnancy Care Following Policy Termination (group only)	$0.00	$0.00	$0.00	$0.00
46	Bone Marrow Testing	$0.01	$0.01	$0.01	$0.01

B. Table 2

The table below shows a side by side comparison of the PMPM costs between the prior PMPM estimates from the initial year of review (i.e. not the 5th year projected cost) compared to the 2016 revised PMPM estimate. The 1st and 3rd columns are the allowed claims cost estimates. The 2nd and 4th columns are the total cost estimates that include the 20% retention assumption, which are based off the paid claims dollars.

Allowed Costs:

		Prior PMPM		2016 Revised PMPM	
	Mandate	Allowed Cost	Total Cost (include retention load)	Allowed Cost	Total Cost (include retention load)
1	Diabetes Self-Management Training	$0.07	$0.07	$0.01	$0.01
2	Prostate Cancer Screening	$0.22	$0.23	$3.33	$2.42
3	Ostomy-Related Supplies	$0.07	$0.07	$0.20	$0.13
4	Hearing Aids for Children Twelve and Under	$0.01	$0.01	$0.00	$0.00
5	Craniofacial Disorders	$0.02	$0.02	$0.15	$0.17
6	Inpatient, Outpatient or One-day Dental Services	$0.06	$0.06	$0.00	$0.00
7	Diabetes Testing and Treatment	$5.45	$5.52	$14.53	$12.81
8	Birth to Three Program	$0.23	$0.26	$0.07	$0.05
9	Lyme Disease Treatments	$0.35	$0.34	$0.41	$0.42
10	Colorectal Cancer Screening	$3.90	$4.08	$5.13	$5.41
11	Tumors and Leukemia	$12.17	$13.20	$70.96	$45.90
12	Mammography and Breast Ultrasound	$3.59	$4.15	$3.07	$3.38
13	Maternity Minimum Stay	$1.97	$2.22	$1.20	$1.25
14	Mastectomy or Lymph Node Dissection Minimum Stay	$0.11	$0.12	$0.02	$0.01
15	Prescription Contraceptives	$2.21	$1.44	$2.99	$2.40
16	Infertility Diagnosis and Treatment	$3.03	$3.36	$1.15	$1.32
17	Autism Spectrum Disorder Therapies	$0.04	$0.03	$0.82	$0.86
18	Coverage for Newborn Infants	$5.09	$5.95	$7.93	$8.83
19	Blood Lead Screening and Risk Assessment	$0.01	$0.01	$0.02	$0.02
20	Preventive Pediatric Care (group only)	$1.98	$2.29	$3.04	$3.80
21	Low Protein Modified Food Products, Amino Acid Modified Preparations and Specialized Formulas	$0.25	$0.29	$0.35	$0.43
22	Neuropsychological Testing for Children Diagnosed with Cancer	$0.00	$0.00	$0.00	$0.00
23	Psychotropic Drug Availability	$9.65	$9.00	$10.11	$9.33
24	Mental Health or Nervous Conditions	$10.55	$10.20	$44.33	$39.78
25	Accidental Ingestion or Consumption of Controlled Drug	$0.03	$0.04	$0.09	$0.04

	Mandate	Prior PMPM		2016 Revised PMPM	
		Allowed Cost	Total Cost (include retention load)	Allowed Cost	Total Cost (include retention load)
26	Denial of Coverage Prohibited for Health Care Services to Persons with an Elevated Blood Alcohol Content	$0.04	$0.04	$0.37	$0.35
27	Treatment of Medical Complications of Alcoholism (group only)	$0.40	$0.44	$22.35	$19.81
28	Occupational Therapy	$1.59	$1.03	$0.38	$0.26
29	Services of Physician Assistants and Certain Nurses	$0.00	$0.00	$0.00	$0.00
30	Services Provided by the Veterans' Home	$0.45	$0.40	$0.00	$0.00
31	Direct Access to OB/GYNs	$0.00	$0.00	$0.00	$0.00
32	Chiropractic Services	$3.55	$3.04	$3.23	$2.13
33	Experimental Treatments	$0.00	$0.00	$0.00	$0.00
34	Off-label Use of Cancer, MS, Parkinson's Drugs	N/A	$3.43	$3.54	$7.20
35	Cancer Clinical Trials	$0.00	$0.00	$0.00	$0.00
36	Hypodermic Needles and Syringes	$0.09	$0.06	$0.00	$0.00
37	Prescription Drugs Removed from Formulary	$0.00	$0.02	$0.00	$0.00
38	Home Health Care	$1.60	$1.76	$0.23	$0.24
39	Ambulance Services	$2.36	$2.73	$3.89	$2.63
40	Prescription Drug Coverage/Mail-Order Pharmacies	$0.00	$0.00	$0.00	$0.00
41	Co-payments Regarding In-Network Imaging Services	$0.00	$1.20	$0.00	$1.70
42	Comprehensive Rehabilitation Services (mandatory offer group only)	$3.93	$2.90	$1.03	$1.02
43	Mobile Field Hospital	$0.00	$0.00	$0.00	$0.00
44	Pain Management	$0.00	$0.00	$0.00	$0.00
45	Maternity Benefits and Pregnancy Care Following Policy Termination (group only)	$0.00	$0.00	$0.00	$0.00
46	Bone Marrow Testing	$0.01	$0.01	$0.01	$0.01

C. Table 3

The table below shows the progression of the paid costs PMPM estimates:
A – reflects the cost estimate for the year in which the mandate was reviewed. For example, Diabetes Self-Management Training mandate was reviewed in the 2010 report. The $0.06 PMPM reflects the 2010 cost estimate.
B – reflects the cost estimate projected out 5 years. For the Diabetes Self-Management Training mandate, $0.07 PMPM reflects the 2014 projected cost estimate using a 5% annual trend assumption that was used in the prior reports.
C – reflects the cost estimate trended out to 2016 using an annual trend assumption of 6% for 2012-2014 and 7% for 2015; These costs were developed in order to more accurately compare how the costs have changed since they were first reviewed.
D – reflects the revised costs estimates using 2013 claims data and projected out to 2016 using an annual trend assumption of 6% for 2012-2014 and 7% for 2015.

		Projected Paid Costs PMPM			
	Mandate	Prior Report 1st Year Estimate (A)	Prior Report 5th Year Projected Estimate (B)	2016 Trended Prior Estimate (C=B*trend)	2016 Revised Estimate (D)
1	Diabetes Self-Management Training	$0.06	$0.07	$0.08	$0.01
2	Prostate Cancer Screening	$0.19	$0.23	$0.25	$1.93
3	Ostomy-Related Supplies	$0.06	$0.07	$0.08	$0.10
4	Hearing Aids for Children Twelve and Under	$0.01	$0.01	$0.01	$0.00
5	Craniofacial Disorders	$0.02	$0.02	$0.03	$0.13
6	Inpatient, Outpatient or One-day Dental Services	$0.05	$0.06	$0.07	$0.00
7	Diabetes Testing and Treatment	$4.60	$5.59	$6.16	$10.25
8	Birth to Three Program	$0.22	$0.27	$0.29	$0.04
9	Lyme Disease Treatments	$0.28	$0.34	$0.38	$0.34
10	Colorectal Cancer Screening	$3.40	$4.71	$4.56	$4.33
11	Tumors and Leukemia	$11.00	$13.37	$14.74	$36.72
12	Mammography and Breast Ultrasound	$3.46	$3.24	$4.58	$2.70
13	Maternity Minimum Stay	$1.85	$2.25	$2.48	$1.00
14	Mastectomy or Lymph Node Dissection Minimum Stay	$0.10	$0.12	$0.13	$0.01
15	Prescription Contraceptives	$1.20	$1.46	$1.61	$1.92
16	Infertility Diagnosis and Treatment	$2.80	$2.40	$3.75	$1.06
17	Autism Spectrum Disorder Therapies	$0.03	$0.04	$0.74	$0.69
18	Coverage for Newborn Infants	$4.96	$6.03	$6.65	$7.06
19	Blood Lead Screening and Risk Assessment	$0.01	$0.01	$0.01	$0.01

	Mandate	Projected Paid Costs PMPM			
		Prior Report 1st Year Estimate (A)	Prior Report 5th Year Projected Estimate (B)	2016 Trended Prior Estimate (C=B*trend)	2016 Revised Estimate (D)
20	Preventive Pediatric Care (group only)	$1.91	$2.40	$2.65	$3.05
21	Low Protein Modified Food Products, Amino Acid Modified Preparations and Specialized Formulas	$0.24	$0.29	$0.32	$0.34
22	Neuropsychological Testing for Children Diagnosed with Cancer	$0.00	$0.00	$0.00	$0.00
23	Psychotropic Drug Availability	$7.50	$10.02	$11.57	$7.47
24	Mental Health or Nervous Conditions	$8.50	$10.33	$11.39	$31.82
25	Accidental Ingestion or Consumption of Controlled Drug	$0.03	$0.04	$0.04	$0.03
26	Denial of Coverage Prohibited for Health Care Services to Persons with an Elevated Blood Alcohol Content	$0.03	$0.04	$0.04	$0.28
27	Treatment of Medical Complications of Alcoholism (group only)	$0.37	$0.45	$0.50	$15.85
28	Occupational Therapy	$0.86	$1.05	$1.15	$0.21
29	Services of Physician Assistants and Certain Nurses	$0.00	$0.00	$0.00	$0.00
30	Services Provided by the Veterans' Home	$0.33	$0.40	$0.44	$0.00
31	Direct Access to OB/GYNs	$0.00	$0.00	$0.00	$0.00
32	Chiropractic Services	$2.53	$3.08	$3.39	$1.71
33	Experimental Treatments	$0.00	$0.01	$0.00	$0.00
34	Off-label Use of Cancer, MS, Parkinson's Drugs	$2.86	$3.31	$3.83	$5.76
35	Cancer Clinical Trials	$0.00	$0.00	$0.00	$0.00
36	Hypodermic Needles and Syringes	$0.05	$0.06	$0.07	$0.00
37	Prescription Drugs Removed from Formulary	$0.02	$0.00	$0.03	$0.00
38	Home Health Care	$1.47	$1.70	$1.97	$0.19
39	Ambulance Services	$2.27	$2.76	$3.04	$2.10
40	Prescription Drug Coverage/Mail-Order Pharmacies	$0.00	$0.00	$0.00	$0.00
41	Co-payments Regarding In-Network Imaging Services	$1.00	$1.22	$1.34	$1.36
42	Comprehensive Rehabilitation Services (mandatory offer group only)	$2.42	$2.94	$3.24	$0.82
43	Mobile Field Hospital	$0.00	$0.00	$0.00	$0.00
44	Pain Management	$0.00	$0.00	$0.00	$0.00
45	Maternity Benefits and Pregnancy Care Following Policy Termination (group only)	$0.00	$0.00	$0.00	$0.00
46	Bone Marrow Testing	$0.01	$0.00	$0.01	$0.01

D. Table 4

The table below reflects the revised cost estimates using 2013 data trended to 2016. The Allowed Claims PMPM costs reflect the paid costs as well as the member cost sharing amount but not retention. The Paid Claims PMPM reflects the cost paid by the insurance carrier after the member cost-sharing. The Total Cost with Retention PMPM reflects the paid claims loaded for administrative costs and profit margin.

		2016 Revised Costs PMPM		
	Mandate	Allowed Cost	Paid Cost	Total Cost with Retention
1	Diabetes Self-Management Training	$0.01	$0.01	$0.01
2	Prostate Cancer Screening	$3.33	$1.93	$2.42
3	Ostomy-Related Supplies	$0.20	$0.10	$0.13
4	Hearing Aids for Children Twelve and Under	$0.00	$0.00	$0.00
5	Craniofacial Disorders	$0.15	$0.13	$0.17
6	Inpatient, Outpatient or One-day Dental Services	$0.00	$0.00	$0.00
7	Diabetes Testing and Treatment	$14.53	$10.25	$12.81
8	Birth to Three Program	$0.07	$0.04	$0.05
9	Lyme Disease Treatments	$0.41	$0.34	$0.42
10	Colorectal Cancer Screening	$5.13	$4.33	$5.41
11	Tumors and Leukemia	$70.96	$36.72	$45.90
12	Mammography and Breast Ultrasound	$3.07	$2.70	$3.38
13	Maternity Minimum Stay	$1.20	$1.00	$1.25
14	Mastectomy or Lymph Node Dissection Minimum Stay	$0.02	$0.01	$0.01
15	Prescription Contraceptives	$2.99	$1.92	$2.40
16	Infertility Diagnosis and Treatment	$1.15	$1.06	$1.32
17	Autism Spectrum Disorder Therapies	$0.82	$0.69	$0.86
18	Coverage for Newborn Infants	$7.93	$7.06	$8.83
19	Blood Lead Screening and Risk Assessment	$0.02	$0.01	$0.02
20	Preventive Pediatric Care (group only)	$3.04	$3.05	$3.80
21	Low Protein Modified Food Products, Amino Acid Modified Preparations and Specialized Formulas	$0.35	$0.34	$0.43
22	Neuropsychological Testing for Children Diagnosed with Cancer	$0.00	$0.00	$0.00
23	Psychotropic Drug Availability	$10.11	$7.47	$9.33
24	Mental Health or Nervous Conditions	$44.33	$31.82	$39.78

		2016 Revised Costs PMPM		
	Mandate	Allowed Cost	Paid Cost	Total Cost with Retention
25	Accidental Ingestion or Consumption of Controlled Drug	$0.09	$0.03	$0.04
26	Denial of Coverage Prohibited for Health Care Services to Persons with an Elevated Blood Alcohol Content	$0.37	$0.28	$0.35
27	Treatment of Medical Complications of Alcoholism (group only)*	$22.35	$15.85	$19.81
28	Occupational Therapy	$0.38	$0.21	$0.26
29	Services of Physician Assistants and Certain Nurses	$0.00	$0.00	$0.00
30	Services Provided by the Veterans' Home	$0.00	$0.00	$0.00
31	Direct Access to OB/GYNs	$0.00	$0.00	$0.00
32	Chiropractic Services	$3.23	$1.71	$2.13
33	Experimental Treatments	$0.00	$0.00	$0.00
34	Off-label Use of Cancer, MS, Parkinson's Drugs	$3.54	$5.76	$7.20
35	Cancer Clinical Trials	$0.00	$0.00	$0.00
36	Hypodermic Needles and Syringes	$0.00	$0.00	$0.00
37	Prescription Drugs Removed from Formulary	$0.00	$0.00	$0.00
38	Home Health Care	$0.23	$0.19	$0.24
39	Ambulance Services	$3.89	$2.10	$2.63
40	Prescription Drug Coverage/Mail-Order Pharmacies	$0.00	$0.00	$0.00
41	Co-payments Regarding In-Network Imaging Services	$0.00	$1.36	$1.70
42	Comprehensive Rehabilitation Services (mandatory offer group only)	$1.03	$0.82	$1.02
43	Mobile Field Hospital	$0.00	$0.00	$0.00
44	Pain Management	$0.00	$0.00	$0.00
45	Maternity Benefits and Pregnancy Care Following Policy Termination (group only)	$0.00	$0.00	$0.00
46	Bone Marrow Testing	$0.01	$0.01	$0.01

Appendix IV. List of Acronyms

Term	Definition
AAP	American Academy of Pediatrics
ACA	Affordable Care Act
ACIP	Advisory Committee on Immunization Practices, Centers for Disease Control
ACOG	American Congress of Obstetricians and Gynecologists
ACR	American College of Radiology
ACS	American Cancer Society
ADA	American Diabetes Association
ASD	Autism Spectrum Disorder
CCIIO	Center for Consumer Information and Insurance Oversight
CFR	Code of Federal Regulations
CGS	Connecticut General Statutes
CHIP	Children's Health Insurance Program
CID	Connecticut Insurance Department
CMS	Centers for Medicare & Medicaid Services
CPHHP	University of Connecticut Center for Public Health and Health Policy
CPT	Current Procedural Terminology
CT / CAT	Computed Tomography / Computer Assisted Tomography
DSME	Diabetes self-management education
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
ERISA	Employee Retirement Income Security Act
EHB	Essential Health Benefits
EPSDT	Early Period Screening, Diagnostic, and Treatment
FAQ	Frequently asked questions
FDA	Food and Drug Administration
Fed. Reg.	Federal Register
FEDVIP	Federal Employee Dental and Vision Insurance Plan
FEHBP	Federal Employees Health Benefit Program
HMO	Health Maintenance Organization
HHS	United States Department of Health and Human Services

Term	Definition
HRSA	Health Resources and Services Administration
HUSKY	Healthcare for Uninsured Kids and Youth
IDSA	Infectious Disease Society of America
ILADS	International Lyme and Associated Diseases Society
MRI	Magnetic Resonance Imaging
PA	Connecticut Public Act
PET	Positron Emission Tomography
PMPM	Per member per month
Pub. L.	United States Public Law
QHP	Qualified Health Plan
PSA	Prostate Specific Antigen
USC	United States Code
USP	United States Pharmacopeia
USPSTF	United States Preventative Services Task Force

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