State of Small Business Healthcare in CT

Report for the Governor's Healthcare
Reform Advisory Board
Presented by
Governor's Business Appointee
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National Federation of Independent Business in CT

- Thousands of CT NFIB Independent Businesses
  - Small independently owned and operated
- Hundreds of thousands of NFIB businesses in the US
  - Some employ hundreds, some employ thousands, most employ less than 50 employees

Define Small Business

- Small business employs 90% of those working in the US
- US Commerce Department says that Small Business is any business with $250 million in sales or less
  - But most are defined as companies with less than 50 employees (<50)

CT Small Business Facts

- Most small businesses in CT are owned and operated by their owners and employees
- 90% of Doctors and Specialists are Small Businesses with less than 5 partners plus staff
  - Most innovations for improving Medical Service Delivery methods are being made by entrepreneurs and companies with less than 50 ee's
- Pay is a combination of salary, benefits, and retirement investment
  - Productivity is important to employers
  - Job security is important to employees
- Success is having both at the same time

Salary and Benefits Defined

- Salary is defined by good pay for managed productivity with regular increases to keep up with inflation and to reward success
- Health and welfare benefits are medical and hospital insurance, other health such as dental, life, disability, long term care insurance, etc.
- Retirement can be defined benefit or defined contribution sponsored by employer
- There is constant tension between salary raises and rising benefit costs

Most employers do not like:

- High employee turnover especially in highly skilled jobs
- Unhappy employees
- Unpredictable overhead costs
- Benefits competition for new hires
- Lack of competition in products that they buy, of which, Health Insurance is one of those purchased products
- The annual 'renewal exercise' to find best price with best benefits for the dollar

<50 ee's Health benefits problems

- Health insurance market is highly regulated and few insurance companies choose to do business in CT, this lessens competition.
  - There are 9 companies conducting small group business in CT
- Overabundance of mandates (56) ultimately are paid for by employers i.e. employees in restricted increases in salary and higher co- pays for premiums
  - Even more CT mandates (7) are waiting in the wings for 2010
- Lack of even tax treatment for sole proprietors vs. group policies causes them to most often choose not to purchase health insurance.
  - They are part of the uninsured for this reason

<50 ee's health benefits challenges

- Small group plans must be ERISA compliant while >50 employers do not have to be
  - means that >50 groups have 7 federal mandates vs. 56 CT mandates for <50 small groups and individuals
- Unpredictable premiums from year to year
- CT has the highest premiums in country except for MA which has universal health insurance
  - which resulted in the highest premiums and now they have proposed cutting costs by cutting benefits
  - CT rates equally with heavily mandated and regulated states of MD, NY, and NJ
- CT employers are competing with other states for business as well as employees
  - high health insurance costs place them at a disadvantage

Limited competition results in:

- Few companies to choose from (in CT - 9 for small group)
- Pricing in a very narrow range
- Employee benefits that are regularly modified to reduce the sticker shock and make them 'affordable' to all
- Employers must work hard to understand the terms of each proposal, which is not really their business focus but is necessary
- Work must be done to make sure employees have equanimity in their benefit package

So, how does health insurance get into the hands of the employer and their employees?

- The process is started about one month before the 'renewal' pricing is known
- For annually renewing companies, all plans, their premiums and their policies, are presented by agents or benefit brokers in order to see what the lay of the land is for the new year
- The owner, HR person, or other representative in the company meets with the agent or benefit broker to discuss and compare the current rates with the renewal ones
- The shock is temporary, then the process begins again to reduce the benefits, increase the employee's co-pays or both

Is there then a need for a "connector"?

- Agents and brokers can currently be viewed as our 'connector' now
  - Insurance plans are highly regulated right now, made unaffordable by mandate, lack of competition, and unreasonable service expectations by covered persons.
- A connector will not change that and may even make health coverage more costly with less choice
  - This can result in even fewer choices with or without a new government controlled bureaucratic 'connector'

Other problems in CT with health insurance today

- When it comes to the type of health insurance that they want and need, most Covered Persons have no control over the health insurance premium and policy selection for what is really their earned money
- The uninsured 'problem' in CT can be solved by focusing on the needs of those who do not or cannot get insurance while making improvements to the fully insured health insurance market.
  - In CT the most recent count is between 8% and 9.7% are uninsured.
  - That means then that between 92% and 90.3% ARE insured

Problems in CT with health insurance today

- Of the 8-9.7% uninsured education is neglected.
  - Many do no know about current state offered plans such as Medicaid, Charter Oak, and SCHIP for kids
  - A possible solution is to pay the agents and brokers a commission to locate, inform, and enroll eligible citizens in the state programs that are available and do not meet the goals when they were created.
- When it comes to insurance for employers groups with <50 ee's do not have a level playing field with employer groups with >50 ee's
  - Changes need to be made

The small employer rating law in Connecticut
(C.G.S. 38a-567(5))

Risk-class adjusted community rating (means that the insurance company or HMO starts with a small employer base rate and can only adjust that base rate for one or more of the following items)

- Age, but the age brackets can not be less than 5 years (e.g. 20-24, 25-29, 30-34….)
- Gender
- Geographic area, as long as the area is no smaller than a county (a particular county can be split, but needs to be attached to another whole county)
- Industry, provided that any factor used shall be no more than 15% from the average of the highest factor and the lowest factor. Also, any particular factor can not increase by more than 5% per year
- Group size, provided that the ratio of the highest group size factor and the lowest is not greater than 1.25 to 1.0
- Administrative cost savings from the administration of an association group plan provided it reduces the carriers overall retention that is measurable
- Family composition provided the carrier uses one or more of the following billing classifications (I) Employee; (II) employee plus family; (III) employee and spouse; (IV) employee and child; (V) employee plus one dependent; and (VI) employee plus two or more dependents

- A small employer carrier is not required to use any of the above adjustments or they can use all of the above adjustments, the only requirement is whatever they use or don't use needs to be consistent for their entire block of small employer business
- Small Employer is defined as 1 to 50 eligible employees (eligible employee is working at least 30 hours)
- Health Status can not be used for rating purposes in the small employer market.

There are no large group rating laws in the Connecticut statutes

- In fact, only HMO's are required to file rates with the Department for approval,
- All other group insurance rates (large employer as well as small employer) don't have to be filed with the Insurance Department.
- the list of laws that pertain to the small business rates bear no resemblance to the laws which govern large group
- The large group rate structure should still be actuarially sound, but again, insurance companies do not have to file group rates with the Department, only the HMO's do.

The Covered Person's expectations: A right or a choice?

- When a person goes grocery shopping, it is a need, not a right, for them to eat, they choose the food right for them and pay with their own money
- When a person goes for a health exam or for treatment it is a need, not a right, they can choose to have the medical service and pay for it
- Why not allow the consumer to choose which doctor, hospital, and method of payment for sought after medical services?
  - It is their money and it is their health
  - Use of Consumer-Directed Health Plans can help them get 'skin in the game', which can make them better medical services consumers

The Covered Person's expectations: A right or a choice?

- Personal risk management choices have been driven out by mandates and legislative requirements
  - What happened to freedom to choose what plan they want and to an insurance company's freedom to sell to those they want to?
- Today the average covered person has come to expect health services at no or very little cost to them
  - even with rising prices and less benefits
- Insurance is hardly insurance anymore.
  - In many cases insurance merely exchanges dollars, while taking some away for administration, little choice there
  - But, Health Reimbursement Arrangements (HRA) and Health Savings Accounts (HSA) encourage consumers to better manage their health and their money. They can also choose to take advantage of wellness programs which increasingly provide discounts for participants

There are promising trends occurring

- The economy continues to force employers to cut costs – with health benefits a major target. As a result, more employers, and their employees, are choosing consumer-directed health plans (CDHPs)
  - In January 2009, the number of people in the U.S. with high-deductible health plan coverage rose to eight million.
  - According to another survey, more than 51 percent of employers now offer a CDHP as an option and another 8 percent are expected to offer one by 2010.
  - Employers are now choosing CDHPs over HMOs. CDHPs cover 15.4 percent of employees, while HMOs cover 13.6 percent.
  - CDHPs grew at a rate of 33.9 percent in 2009.

There are promising trends occurring

- Another trend is that employers now offer more CDHPs linked to health savings accounts (HSAs) than to health reimbursement arrangements (HRAs).
  - According to one study, 56 percent offer HSAs, 35 percent offer HRAs and 9 percent offer both.
- Cost is a primary reason for the continued growth in the number of employers who offer CDHPs.
  - Between rising health care costs and current economic pressures, businesses need to cut costs where they can. One study found that the trend for CDHP premium costs is as much as 40 percent lower than managed-care insurance.
- Recent surveys by Buck Consultants show that 96 percent of employers who have offered HSAs for more than three years said that their plans allowed them to continue offering health benefits to their employees. And 86 percent said that their plan costs were the same or less than the previous year.

There are promising trends occurring

- CDHPs help lower costs is through the promotion of consumerism. The biggest challenge to managing health care costs cited by employers is poor employee health habits.
  - Employees with CDHPs use more generic drugs, make fewer emergency room visits and participate more in wellness programs
- More than half of HSA account holders said they monitor their health more closely.
  - Specifically, they read their medical bills more closely, have a better understanding of where their money goes and evaluate costs before choosing medical services

- **The overall consensus is that CDHPs, and HSAs in particular, are likely to continue to grow even with reform on the way**

- The previous three slides contain information provided by Aetna contained in their Agent newsletter for December 2009 an article titled " CDHP's: Finding their place in the changing healthcare environment"

There are promising trends occurring

- New price and quality transparency programs are coming on line
- Concierge and medical home treatment programs are being developed
- Consumers are learning how to shop for and procure competitively offered medical treatments
- Insurance companies are focusing on wellness and prevention and offer discounts for compliance
- Emphasis is increasingly placed on ownership of insurance policies through the individual market
  - The Senators "Wyden/Collins Amendment" which creates 'Healthcare Vouchers" with emphasis on individual insurance policies
  - In some cases parents and grandparents are stepping up and buying policies for new graduates or newly independent children which they can keep for their lifetime
  - Policies that do not rely on employment are gaining favor for those who value their career independence

Some recommendations and ideas to consider supporting

- If there is an agreement in the Senate, and they prevail in conference, it is certain that some states will be able to conduct their own pilot programs.
  - We should be sure to apply for CT to be one of the states selected
- Advocate a level playing field for <50 employee groups vs. their >50 employee groups
  - especially where it comes to mandates by contacting the legislature ask that they remedy this situation asap
- Every effort should be taken to lower the uninsured numbers in CT by thinking 'out of the box'
  - create more effective outreach and enrollment policies
- Support novel ideas like the "Wyden/Collins Amendment"
  - which creates 'Healthcare Vouchers"
- Investigate regional states cross-border sales of insurance policies

Thank you for the opportunity to present our ideas to you

- Backup information is available and will be provided upon request by contacting me at rickwillard@usa.com
- The National Federation of Independent Business (NFIB) (www.nfib.com) is the nation's leading small-business advocacy organization. A non-profit, non-partisan association founded in 1943, NFIB represents the consensus views of its members in Washington and all 50 state capitals.
- Other links of interest from the NFIB
  - http://www.nfib.com/research-foundation/health-policy/
  - http://www.411sbfacts.com/index.html
  - http://www.cga.ct.gov/2009/rpt/2009-R-0317.htm
  - http://www.nfib.com/issues-elections/issues-elections-item/cmsid/50271/
  - http://www.nfib.com/issues-elections/healthcare/

OLR RESEARCH REPORT

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Revised

STATE MANDATED HEALTH INSURANCE BENEFITS

By: Janet L. Kaminski Leduc, Senior Legislative Attorney

You asked for an update of OLR Research Report 2007-R-0703, which provides a list of state mandated health insurance benefits.

In Connecticut, health insurance mandates are contained in Chapter 700c of the general statutes. Each benefit mandate statute identifies the plans to which it applies. Many apply to both individual and group health insurance policies, including those insured plans issued to small employer groups.

Due to federal law (ERISA), state benefit mandates generally do not apply to self-insured plans.

Table 1 provides a list of Connecticut's mandated benefits. See OLR Research Report 2008-R-0138 for a list of health care providers and facilities that, by law, health insurance policies must cover.

Table 1: Connecticut Health Care Insurance Mandated Benefits

CGS §	*Mandate*	*Group, Individual, or Both*	*Description*
38a-476(b)(1)	Preexisting Condition Coverage	Group	May not impose preexisting condition exclusion beyond 12 months after effective date of coverage, and exclusion may only relate to conditions for which medical advice, diagnosis, care, or treatment was recommended or received six months before the policy's effective date.
38a-476(b)(2)	Preexisting Condition Coverage	Individual, except for short-term policy	May not impose preexisting condition exclusion beyond 12 months after effective date of coverage, and exclusion may only relate to conditions for which medical advice, diagnosis, care, or treatment was recommended or received 12 months before the policy's effective date.
38a-476(g)	Preexisting Condition Coverage	Individual short-term policy	May not impose preexisting condition exclusion beyond 12 months after effective date of coverage, and exclusion may only relate to conditions for which medical advice, diagnosis, care, or treatment was recommended or received 24 months before the policy's effective date.
38a-476b	Availability of Psychotropic Drugs	Both	No mental health care benefit provided under state law, or with state funds or to state employees may limit the availability of the most effective psychotropic drugs.

38a-483c 38a-513b	Experimental Treatments	Both	Procedures, treatments, or drugs that have completed a Phase III FDA clinical trial. Appeals process expedited for those with a life expectancy of less than two years.
38a-488a 38a-514	Mental Illness	Both	Diagnosis and treatment of mental or nervous conditions. Coverage cannot differ from the terms, conditions, or benefits for the diagnosis or treatment of medical, surgical, or other physical health conditions. Requires a policy to cover a residential treatment facility when a physician, psychiatrist, psychologist, or clinical social worker assesses the person and determines that he or she cannot appropriately, safely, or effectively be treated in another setting.
38a-482 38a-497 38a-554	Children	Both	Under individual health insurance policies, coverage continues at least until the policy anniversary date on or after the date the child (1) marries; (2) ends Connecticut residency, unless he or she is (a) under age 19 or (b) a full-time student at an accredited college; (3) gets coverage under his or her employer's group health plan; or (4) turns age 26. Group comprehensive health care plans must (1) extend coverage eligibility to unmarried children under age 26 and (2) offer continuation coverage to the end of the month in which the child meets the criteria for losing coverage under an individual policy.

CGS §	***Mandate***	***Group, Individual, or Both***	***Description***
38a-489 38a-515 38a-554	Children - Mentally or Physically Handicapped	Both	After passing dependent status and coverage would otherwise end, coverage must continue if child is both mentally or physically handicapped and dependent upon insured for support.
38a-490 38a-508 38a-516 38a-549	Children - Newborns and Adopted	Both	Injury and sickness, including care and treatment of congenital defects and birth abnormalities, for newborns from birth and for adopted children from legal placement for adoption.
PA 09-124	Stepchildren	Both	Effective June 18, 2009 (upon passage), policies must cover stepchildren on the same basis as biological children.
38a-490a 38a-516a	Birth-to-Three	Both	At least $ 3,200 per child annually for medically necessary early invention services, up to $ 9,600 per child over three years.
38a-490b 38a-516b	Children's Hearing Aids	Both	Hearing aids for children 12 and under. Coverage may be limited to $ 1,000 within a 24-month period.
38a-490c 38a-516c	Craniofacial Disorders	Both	Medically necessary orthodontic processes and appliances for treatment of craniofacial disorders for people age 18 or younger. Coverage is not required for cosmetic surgery.
38a-492l 38a-516d	Children with Cancer	Both	Coverage for children diagnosed with cancer after December 31, 1999 for neuropsychological testing a physician orders to assess the extent chemotherapy or radiation treatment has caused the child to have cognitive or developmental delays. Insurers cannot require pre-authorization for the tests.
38a-491a	Dental Coverage	Both	Medically necessary general anesthesia, nursing, and related hospital services for in-patient, outpatient, or one-

38a-517a			day dental services.
38a-492 38a-518	Accidental Ingestion or Consumption of Controlled Drugs	Both	Emergency medical care for the accidental ingestion or consumption of controlled drugs. Coverage is subject to a minimum of 30 days inpatient care and a maximum $ 500 for outpatient care per calendar year.
38a-492a 38a-518a	Hypodermic Needles and Syringes	Both	Hypodermic needles and syringes prescribed by a prescribing practitioner for administering medications.

CGS §	***Mandate***	***Group, Individual, or Both***	***Description***
38a-492b 38a-518b	Off-Label Cancer Drugs	Both	If a prescription drug is recognized for treatment of a specific type of cancer, a policy cannot exclude coverage of the drug when it is used for another type of cancer.
38a-492c 38a-518c	Protein Modified Food and Specialized Formula	Both	Amino acid modified and low protein modified food products when prescribed for the treatment of inherited metabolic diseases and cystic fibrosis. Medically necessary specialized formula for children up to age 12. Food and formula must be administered under the direction of a physician. Coverage for preparations, food products, and formulas must be on the same basis as coverage outpatient prescription drugs.
38a-492d 38a-518d	Diabetes	Both	Laboratory and diagnostic tests for all types of diabetes. Medically necessary equipment, drugs, and supplies for insulin-dependent, insulin using, gestational, and non-insulin using diabetes.
38a-492e 38a-518e	Diabetes Self-Management Training	Both	Outpatient self-management training prescribed by a licensed health care professional. Coverage is subject to the same terms and conditions as other policy benefits.
38a-492f 38a-518f	Prescription Drugs Removed from Formulary	Both	A prescription drug that has been removed from the list of covered drugs must be continued if the insured was previously using the drug for the treatment of a chronic illness and it is deemed medically necessary.
38a-492g 38a-518g	Prostate Screening	Both	Laboratory and diagnostic tests to screen for prostate cancer for men who are symptomatic, have a family history, or are over 50.
38a-492h 38a-518h	Lyme Disease Treatment	Both	Lyme disease treatment including not less that 30 days of intravenous antibiotic therapy, 60 days of oral antibiotic therapy, or both, and further treatment if recommended by a rheumatologist, infectious disease specialist, or neurologist.
38a-492i 38a-518i	Pain Management	Both	Access to a pain management specialist and coverage for pain treatment ordered by such specialist.

CGS §	***Mandate***	***Group, Individual, or Both***	***Description***
38a-492j 38a-518j	Ostomy Appliances and Supplies	Both	If policy covers ostomy surgery, policy must also cover up to $ 1000 per year for medically necessary ostomy-related appliances and supplies.
38a-492k 38a-518k	Colorectal Cancer Screening	Both	Colorectal cancer screening. Frequency of screening to be based on recommendations by the American College of Gastroenterology.
38a-493	Home Health Care	Both	Home health care including (1) part-time or intermittent nursing care and home health aide services; (2)

38a-520			physical, occupational, or speech therapy; (3) medical supplies, drugs and medicines; and (4) medical social services. Coverage can be limited to no less than 80 visits per year and, for a terminally ill person, no more than $ 200 for medical social services. Coverage can be subject to an annual deductible of no more than $ 50 and a coinsurance of no less than 75%, except that a high deductible plan used to establish a medical savings account is exempt from the deductible limit.
38a-523	Comprehensive Rehabilitation Services	Group	Group health insurance must offer coverage for comprehensive rehabilitation services, including (1) physician services, physical and occupational therapy, nursing care, psychological and audiological services, and speech therapy; (2) social services provided by a social worker; (3) respiratory therapy; (4) prescription drugs and medicines; (5) prosthetic and orthotic devices and; (6) other supplies and services prescribed by a doctor.
38a-496 38a-524	Occupational Therapy	Both	If policy covers physical therapy, it must provide coverage for occupational therapy.
38a-498 38a-525	Ambulance Services	Both	Ambulance service when medically necessary. Payment must be on a direct pay basis where notice of assignment is reflected on the bill.

CGS §	***Mandate***	***Group, Individual, or Both***	***Description***
38a-498a 38a-525a	911 Calls	Both	Cannot require preauthorization for 911 calls.
38a-498b 38a-525b	Mobile Field Hospitals	Both	Benefits for isolation care and emergency services provided by mobile field hospitals, previously called critical access hospitals. Such benefits are subject to any policy provisions that apply to other covered services. The rates a policy pays must be equal to the rates Medicaid pays, as determined by the Department of Social Services.
38a-498c 38a-525c	Injured and Under the Influence	Both	Insurance polices prohibited from denying coverage for health care services rendered to an injured insured person if the injury is alleged to have occurred or occurs when the person has an elevated blood alcohol level (0. 08% or more) or is under the influence of drugs or alcohol.
38a-501	Long-Term Care Policy – Non-Forfeiture	Individual	Prohibits an insurer from issuing or delivering a long-term care policy on or after July 1, 2008 unless it had offered the prospective insured an optional non-forfeiture benefit during the policy solicitation or application process. If the non-forfeiture option is declined, the insurer must give the insured a contingent benefit upon lapse.
38a-501	Long-Term Care Policy – Elimination Period	Individual	Changes the elimination period required under a long-term care insurance policy. Prior law required a "reasonable" elimination period (i. e. , a waiting period after the onset of the injury, illness, or function loss during which no benefits are payable). The act instead requires an elimination period that is (1) up to 100 days of confinement or (2) between 100 days and two years of confinement if an irrevocable trust is in place that is estimated to be sufficient to cover the person's confinement costs during this period. Sets requirements for the trust.

38a-503 38a-530	Mammography and Breast Cancer Screening	Both	Baseline mammogram for woman 35 to 39 and one every year for woman 40 and older. Additional coverage must be provided for a comprehensive ultrasound screening of a woman's entire breast(s) if (1) a mammogram shows heterogeneous or dense breast tissue based on BI-RADS or (2) she is at increased breast cancer risk because of family history, her prior history, genetic testing, or other indications determined by her physician or advanced-practice nurse. Coverage is subject to any policy provisions applicable to other covered services.

CGS §	***Mandate***	***Group, Individual, or Both***	***Description***
38a-503b 38a-530b	Obstetrician-Gynecologist; Pap Smear	Both	Direct access to participating in-network ob-gyn for gynecological examination, care related to pregnancy, and primary and preventive obstetric and gynecologic services required as result of a gynecological examination or condition (includes pap smear). Female enrollees may also designate participating ob-gyn or other doctor as primary care provider.
38a-503c 38a-530c	Maternity Care	Both	Minimum 48-hour hospital stay for mother and newborn after vaginal delivery and minimum 96-hour hospital stay after caesarian delivery.
38a-503d 38a-530d	Mastectomy	Both	Minimum 48-hour hospital stay after mastectomy or lymph node dissection or longer stay if recommended by physician.
38a-503e 38a-530e	Contraceptives	Both	If prescription drugs are covered, then prescription contraceptives must be covered. An employer or individual may decline contraceptive coverage if it conflicts with religious beliefs.
38a-533	Alcoholism	Group	Expenses incurred in connection with medical complications of alcoholism such as cirrhosis of the liver, gastrointestinal bleeding, pneumonia, and delirium tremens.
38a-507 38a-534	Chiropractic Services	Both	Cover chiropractor services to same extent as coverage for a physician.
38a-535	Preventive Pediatric Care	Group	Preventive pediatric care at the following intervals (1) every 2 months from birth to 6 months, (2) every 3 months from 9 to 18 months, and (3) annually from 2 to 6 years of age. Coverage is subject to any policy provisions that apply to other services covered under the policy.
38a-535	Lead Screening	Both	Coverage for blood lead screening and risk assessments ordered by primary care providers in accordance with the act.
38a-509 38a-536	Infertility	Both	Medically necessary costs of diagnosing and treating infertility.
38a-542(a)&(b)	Breast Implant Removal	Group	Medically necessary removal of breast implants implanted on or before July 1, 1994. Annual coverage must be at least $ 1,000 for removal of any such breast implant.

38a-504(a)&(b) 38a-542(a)&(b)	Treatment for Leukemia, Tumors, and Wigs for Chemotherapy Patients	Both	Surgical removal of tumors an treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, non-dental prosthesis, surgical removal of breasts due to tumors, and a wig if prescribed by a licensed oncologist for a patient suffering hair loss due to chemotherapy. Annual coverage must be at least $ 500 for surgical tumor removal, $ 500 for reconstructive surgery, $ 500 for outpatient chemotherapy, $ 350 for a wig, and $ 300 for prosthesis, except for surgical removal of breasts due to tumors, the prosthesis benefit must be at least $ 300 for each breast removed.
38a-504(c) 38a-542(c)	Breast Reconstruction after Mastectomy	Both	Reconstructive surgery on non-diseased breast for symmetrical appearance. Coverage is subject to the same terms and conditions as other benefits under the policy.
38a-504a – 38a-504g; 38a-542a – 38a-542g	Cancer Clinical Trials	Both	Routine patient costs relating to cancer clinical trials. Out-of-network hospitalization paid as in-network benefit if services are not available in-network. Such trials must have peer-reviewed protocols approved by one of several federal organizations.
38a-511 38a-550	Copays for Imaging Services (MRIs, CAT scans, and PET scans)	Both	Limits copays for MRIs and CAT scans to no more than (1) $ 375 for all such services annually and (2) $ 75 for each one. Limits copays for PET scans to no more than (1) $ 400 for all such scans annually and (2) $ 100 for each one. Limits not applicable if (1) the ordering physician performs the service or is in the same practice group as the one who does and (2) to high deductible health plans designed to compatible with federally qualified Health Savings Accounts.
PA 07-75	Medically Necessary Definition	Both	Specifies the definition of "medically necessary" that policies must include.
PA 08-132, PA 09-115	Autism Spectrum Disorders	Group	Effective January 1, 2009, policies must cover physical, speech, and occupational therapy services provided to treat autism spectrum disorders if the policies cover these services for other diseases and conditions. Effective January 1, 2010, policies must cover the diagnosis and treatment of autism spectrum disorders, including (1) behavioral therapy for a child age 14 or younger and (2) certain prescription drugs and psychiatric and psychological services. A policy can limit coverage for behavioral therapy to $ 50,000 a year for a child age eight or younger, $ 35,000 for a child from age nine to 12, and $ 25,000 for a 13-or 14-year-old.
PA 09-51	Epidermolysis Bullosa	Both	Effective January 1, 2010, policies must cover wound care supplies that are medically necessary to treat epidermolysis bullosa (a rare skin disorder) and administered under a physician's direction.
PA 09-136	Prescription Eye Drops	Both	Effective January 1, 2010, policies that provide prescription eye drop coverage cannot deny coverage for prescription renewals when (1) the refill is requested by the insured person less than 30 days from either (a) the date the original prescription was given to the insured or (b) the last date the prescription refill was given to the insured, whichever is later, and (2) the prescribing physician indicates on the original prescription that additional quantities are needed and the refill request does not exceed this amount.