



General Assembly

February Session, 2008

**Raised Bill No. 309**

LCO No. 1903

\*01903\_\_\_\_\_INS\*

Referred to Committee on Insurance and Real Estate

Introduced by:  
(INS)

***AN ACT CONCERNING CERTAIN HEALTH INSURANCE MANDATES.***

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

1 Section 1. Section 38a-488a of the 2008 supplement to the general  
2 statutes is repealed and the following is substituted in lieu thereof  
3 (*Effective January 1, 2009*):

4 (a) Each individual health insurance policy providing coverage of  
5 the type specified in subdivisions (1), (2), (4), (11) and (12) of section  
6 38a-469 delivered, issued for delivery, renewed, amended or continued  
7 in this state on or after January 1, 2000, shall provide benefits for the  
8 diagnosis and treatment of mental or nervous conditions. For the  
9 purposes of this section, "mental or nervous conditions" means mental  
10 disorders, as defined in the most recent edition of the American  
11 Psychiatric Association's "Diagnostic and Statistical Manual of Mental  
12 Disorders". "Mental or nervous conditions" does not include (1) mental  
13 retardation, (2) learning disorders, (3) motor skills disorders, (4)  
14 communication disorders, (5) caffeine-related disorders, (6) relational  
15 problems, and (7) additional conditions that may be a focus of clinical  
16 attention, that are not otherwise defined as mental disorders in the  
17 most recent edition of the American Psychiatric Association's

18 "Diagnostic and Statistical Manual of Mental Disorders".

19 (b) No such policy shall establish any terms, conditions or benefits  
20 that place a greater financial burden on an insured for access to  
21 diagnosis or treatment of mental or nervous conditions than for  
22 diagnosis or treatment of medical, surgical or other physical health  
23 conditions.

24 (c) In the case of benefits payable for the services of a licensed  
25 physician, such benefits shall be payable for the same services when  
26 such services are lawfully rendered by a psychologist licensed under  
27 the provisions of chapter 383 or by such a licensed psychologist in a  
28 licensed hospital or clinic.

29 [(d) In the case of benefits payable for the services of a licensed  
30 physician or psychologist, such benefits shall be payable for the same  
31 services when such services are rendered by:

32 (1) A clinical social worker who is licensed under the provisions of  
33 chapter 383b and who has passed the clinical examination of the  
34 American Association of State Social Work Boards and has completed  
35 at least two thousand hours of post-master's social work experience in  
36 a nonprofit agency qualifying as a tax-exempt organization under  
37 Section 501(c) of the Internal Revenue Code of 1986 or any subsequent  
38 corresponding internal revenue code of the United States, as from time  
39 to time amended, in a municipal, state or federal agency or in an  
40 institution licensed by the Department of Public Health under section  
41 19a-490;

42 (2) A social worker who was certified as an independent social  
43 worker under the provisions of chapter 383b prior to October 1, 1990;

44 (3) A licensed marital and family therapist who has completed at  
45 least two thousand hours of post-master's marriage and family therapy  
46 work experience in a nonprofit agency qualifying as a tax-exempt  
47 organization under Section 501(c) of the Internal Revenue Code of 1986

48 or any subsequent corresponding internal revenue code of the United  
49 States, as from time to time amended, in a municipal, state or federal  
50 agency or in an institution licensed by the Department of Public Health  
51 under section 19a-490;

52 (4) A marital and family therapist who was certified under the  
53 provisions of chapter 383a prior to October 1, 1992;

54 (5) A licensed alcohol and drug counselor, as defined in section 20-  
55 74s, or a certified alcohol and drug counselor, as defined in section 20-  
56 74s; or

57 (6) A licensed professional counselor.]

58 [(e)] (d) For purposes of this section, the term "covered expenses"  
59 means the usual, customary and reasonable charges for treatment  
60 deemed necessary under generally accepted medical standards, except  
61 that in the case of a managed care plan, as defined in section 38a-478,  
62 "covered expenses" means the payments agreed upon in the contract  
63 between a managed care organization, as defined in section 38a-478,  
64 and a provider, as defined in section 38a-478.

65 [(f) (1) In the case of benefits payable for the services of a licensed  
66 physician, such benefits shall be payable for (A) services rendered in a  
67 child guidance clinic or residential treatment facility by a person with a  
68 master's degree in social work or by a person with a master's degree in  
69 marriage and family therapy under the supervision of a psychiatrist,  
70 physician, licensed marital and family therapist, or licensed clinical  
71 social worker who is eligible for reimbursement under subdivisions (1)  
72 to (4), inclusive, of subsection (d) of this section; (B) services rendered  
73 in a residential treatment facility by a licensed or certified alcohol and  
74 drug counselor who is eligible for reimbursement under subdivision  
75 (5) of subsection (d) of this section; or (C) services rendered in a  
76 residential treatment facility by a licensed professional counselor who  
77 is eligible for reimbursement under subdivision (6) of subsection (d) of  
78 this section.

79 (2) In the case of benefits payable for the services of a licensed  
80 psychologist under subsection (d) of this section, such benefits shall be  
81 payable for (A) services rendered in a child guidance clinic or  
82 residential treatment facility by a person with a master's degree in  
83 social work or by a person with a master's degree in marriage and  
84 family therapy under the supervision of such licensed psychologist,  
85 licensed marital and family therapist, or licensed clinical social worker  
86 who is eligible for reimbursement under subdivisions (1) to (4),  
87 inclusive, of subsection (d) of this section; (B) services rendered in a  
88 residential treatment facility by a licensed or certified alcohol and drug  
89 counselor who is eligible for reimbursement under subdivision (5) of  
90 subsection (d) of this section; or (C) services rendered in a residential  
91 treatment facility by a licensed professional counselor who is eligible  
92 for reimbursement under subdivision (6) of subsection (d) of this  
93 section.

94 (g) In the case of benefits payable for the service of a licensed  
95 physician practicing as a psychiatrist or a licensed psychologist, under  
96 subsection (d) of this section, such benefits shall be payable for  
97 outpatient services rendered (1) in a nonprofit community mental  
98 health center, as defined by the Department of Mental Health and  
99 Addiction Services, in a nonprofit licensed adult psychiatric clinic  
100 operated by an accredited hospital or in a residential treatment facility;  
101 (2) under the supervision of a licensed physician practicing as a  
102 psychiatrist, a licensed psychologist, a licensed marital and family  
103 therapist, a licensed clinical social worker, a licensed or certified  
104 alcohol and drug counselor or a licensed professional counselor who is  
105 eligible for reimbursement under subdivisions (1) to (6), inclusive, of  
106 subsection (d) of this section; and (3) within the scope of the license  
107 issued to the center or clinic by the Department of Public Health or to  
108 the residential treatment facility by the Department of Children and  
109 Families.]

110 [(h)] (e) Except in the case of emergency services or in the case of  
111 services for which an individual has been referred by a physician

112 affiliated with a health care center, nothing in this section shall be  
113 construed to require a health care center to provide benefits under this  
114 section through facilities that are not affiliated with the health care  
115 center.

116 [(i)] (f) In the case of any person admitted to a state institution or  
117 facility administered by the Department of Mental Health and  
118 Addiction Services, Department of Public Health, Department of  
119 Children and Families or the Department of Developmental Services,  
120 the state shall have a lien upon the proceeds of any coverage available  
121 to such person or a legally liable relative of such person under the  
122 terms of this section, to the extent of the per capita cost of such  
123 person's care. Except in the case of emergency services, the provisions  
124 of this subsection shall not apply to coverage provided under a  
125 managed care plan, as defined in section 38a-478.

126 Sec. 2. Section 38a-514 of the 2008 supplement to the general statutes  
127 is repealed and the following is substituted in lieu thereof (*Effective*  
128 *January 1, 2009*):

129 (a) Except as provided in subsection [(j)] (g) of this section, each  
130 group health insurance policy, providing coverage of the type  
131 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469,  
132 delivered, issued for delivery, renewed, amended or continued in this  
133 state on or after January 1, 2000, shall provide benefits for the  
134 diagnosis and treatment of mental or nervous conditions. For the  
135 purposes of this section, "mental or nervous conditions" means mental  
136 disorders, as defined in the most recent edition of the American  
137 Psychiatric Association's "Diagnostic and Statistical Manual of Mental  
138 Disorders". "Mental or nervous conditions" does not include (1) mental  
139 retardation, (2) learning disorders, (3) motor skills disorders, (4)  
140 communication disorders, (5) caffeine-related disorders, (6) relational  
141 problems, and (7) additional conditions that may be a focus of clinical  
142 attention, that are not otherwise defined as mental disorders in the  
143 most recent edition of the American Psychiatric Association's

144 "Diagnostic and Statistical Manual of Mental Disorders".

145 (b) No such group policy shall establish any terms, conditions or  
146 benefits that place a greater financial burden on an insured for access  
147 to diagnosis or treatment of mental or nervous conditions than for  
148 diagnosis or treatment of medical, surgical or other physical health  
149 conditions.

150 (c) In the case of benefits payable for the services of a licensed  
151 physician, such benefits shall be payable for the same services when  
152 such services are lawfully rendered by a psychologist licensed under  
153 the provisions of chapter 383 or by such a licensed psychologist in a  
154 licensed hospital or clinic.

155 [(d) In the case of benefits payable for the services of a licensed  
156 physician or psychologist, such benefits shall be payable for the same  
157 services when such services are rendered by:

158 (1) A clinical social worker who is licensed under the provisions of  
159 chapter 383b and who has passed the clinical examination of the  
160 American Association of State Social Work Boards and has completed  
161 at least two thousand hours of post-master's social work experience in  
162 a nonprofit agency qualifying as a tax-exempt organization under  
163 Section 501(c) of the Internal Revenue Code of 1986 or any subsequent  
164 corresponding internal revenue code of the United States, as from time  
165 to time amended, in a municipal, state or federal agency or in an  
166 institution licensed by the Department of Public Health under section  
167 19a-490;

168 (2) A social worker who was certified as an independent social  
169 worker under the provisions of chapter 383b prior to October 1, 1990;

170 (3) A licensed marital and family therapist who has completed at  
171 least two thousand hours of post-master's marriage and family therapy  
172 work experience in a nonprofit agency qualifying as a tax-exempt  
173 organization under Section 501(c) of the Internal Revenue Code of 1986

174 or any subsequent corresponding internal revenue code of the United  
175 States, as from time to time amended, in a municipal, state or federal  
176 agency or in an institution licensed by the Department of Public Health  
177 under section 19a-490;

178 (4) A marital and family therapist who was certified under the  
179 provisions of chapter 383a prior to October 1, 1992;

180 (5) A licensed alcohol and drug counselor, as defined in section 20-  
181 74s, or a certified alcohol and drug counselor, as defined in section 20-  
182 74s; or

183 (6) A licensed professional counselor.]

184 [(e)] (d) For purposes of this section, the term "covered expenses"  
185 means the usual, customary and reasonable charges for treatment  
186 deemed necessary under generally accepted medical standards, except  
187 that in the case of a managed care plan, as defined in section 38a-478,  
188 "covered expenses" means the payments agreed upon in the contract  
189 between a managed care organization, as defined in section 38a-478,  
190 and a provider, as defined in section 38a-478.

191 [(f) (1) In the case of benefits payable for the services of a licensed  
192 physician, such benefits shall be payable for (A) services rendered in a  
193 child guidance clinic or residential treatment facility by a person with a  
194 master's degree in social work or by a person with a master's degree in  
195 marriage and family therapy under the supervision of a psychiatrist,  
196 physician, licensed marital and family therapist or licensed clinical  
197 social worker who is eligible for reimbursement under subdivisions (1)  
198 to (4), inclusive, of subsection (d) of this section; (B) services rendered  
199 in a residential treatment facility by a licensed or certified alcohol and  
200 drug counselor who is eligible for reimbursement under subdivision  
201 (5) of subsection (d) of this section; or (C) services rendered in a  
202 residential treatment facility by a licensed professional counselor who  
203 is eligible for reimbursement under subdivision (6) of subsection (d) of  
204 this section.

205 (2) In the case of benefits payable for the services of a licensed  
206 psychologist under subsection (d) of this section, such benefits shall be  
207 payable for (A) services rendered in a child guidance clinic or  
208 residential treatment facility by a person with a master's degree in  
209 social work or by a person with a master's degree in marriage and  
210 family therapy under the supervision of such licensed psychologist,  
211 licensed marital and family therapist or licensed clinical social worker  
212 who is eligible for reimbursement under subdivisions (1) to (4),  
213 inclusive, of subsection (d) of this section; (B) services rendered in a  
214 residential treatment facility by a licensed or certified alcohol and drug  
215 counselor who is eligible for reimbursement under subdivision (5) of  
216 subsection (d) of this section; or (C) services rendered in a residential  
217 treatment facility by a licensed professional counselor who is eligible  
218 for reimbursement under subdivision (6) of subsection (d) of this  
219 section.

220 (g) In the case of benefits payable for the service of a licensed  
221 physician practicing as a psychiatrist or a licensed psychologist, under  
222 subsection (d) of this section, such benefits shall be payable for  
223 outpatient services rendered (1) in a nonprofit community mental  
224 health center, as defined by the Department of Mental Health and  
225 Addiction Services, in a nonprofit licensed adult psychiatric clinic  
226 operated by an accredited hospital or in a residential treatment facility;  
227 (2) under the supervision of a licensed physician practicing as a  
228 psychiatrist, a licensed psychologist, a licensed marital and family  
229 therapist, a licensed clinical social worker, a licensed or certified  
230 alcohol and drug counselor, or a licensed professional counselor who  
231 is eligible for reimbursement under subdivisions (1) to (6), inclusive, of  
232 subsection (d) of this section; and (3) within the scope of the license  
233 issued to the center or clinic by the Department of Public Health or to  
234 the residential treatment facility by the Department of Children and  
235 Families.]

236 [(h)] (e) Except in the case of emergency services or in the case of  
237 services for which an individual has been referred by a physician

238 affiliated with a health care center, nothing in this section shall be  
239 construed to require a health care center to provide benefits under this  
240 section through facilities that are not affiliated with the health care  
241 center.

242 [(i)] (f) In the case of any person admitted to a state institution or  
243 facility administered by the Department of Mental Health and  
244 Addiction Services, Department of Public Health, Department of  
245 Children and Families or the Department of Developmental Services,  
246 the state shall have a lien upon the proceeds of any coverage available  
247 to such person or a legally liable relative of such person under the  
248 terms of this section, to the extent of the per capita cost of such  
249 person's care. Except in the case of emergency services the provisions  
250 of this subsection shall not apply to coverage provided under a  
251 managed care plan, as defined in section 38a-478.

252 [(j)] (g) A group health insurance policy may exclude the benefits  
253 required by this section if such benefits are included in a separate  
254 policy issued to the same group by an insurance company, health care  
255 center, hospital service corporation, medical service corporation or  
256 fraternal benefit society. Such separate policy, which shall include the  
257 benefits required by this section and the benefits required by section  
258 38a-533, shall not be required to include any other benefits mandated  
259 by this title.

260 [(k)] (h) In the case of benefits based upon confinement in a  
261 residential treatment facility, such benefits shall be payable only in  
262 situations in which (A) the insured has a serious mental illness which  
263 substantially impairs the person's thought, perception of reality,  
264 emotional process, or judgment or grossly impairs behavior as  
265 manifested by recent disturbed behavior, (B) the insured has been  
266 confined in a hospital for such illness for a period of at least three days  
267 immediately preceding such confinement in a residential treatment  
268 facility, and (C) such illness would otherwise necessitate continued  
269 confinement in a hospital if such care and treatment were not available

270 through a residential treatment center for children and adolescents.

271 [(1)] (i) The services rendered for which benefits are to be paid for  
272 confinement in a residential treatment facility must be based on an  
273 individual treatment plan. For purposes of this section, the term  
274 "individual treatment plan" means a treatment plan prescribed by a  
275 physician with specific attainable goals and objectives appropriate to  
276 both the patient and the treatment modality of the program.

277 Sec. 3. Section 38a-523 of the general statutes is repealed and the  
278 following is substituted in lieu thereof (*Effective January 1, 2009*):

279 (a) For the purposes of this section:

280 (1) "Comprehensive rehabilitation services" shall consist of the  
281 following when provided in a comprehensive rehabilitation facility  
282 pursuant to a plan of care approved in writing by a physician licensed  
283 in accordance with the provisions of chapter 370 and reviewed by such  
284 physician at least every thirty days to determine that continuation of  
285 such services are medically necessary for the rehabilitation of the  
286 patient: (A) Physician services, physical and occupational therapy,  
287 nursing care, psychological and audiological services and speech  
288 therapy provided by health care professionals who are licensed by the  
289 appropriate state licensing authority to perform such services; (B)  
290 [social services by a social worker holding a master's degree from an  
291 accredited school of social work; (C)] respiratory therapy by a certified  
292 respiratory therapist; [(D)] (C) prescription drugs and medicines which  
293 cannot be self-administered; [(E)] (D) prosthetic and orthotic devices,  
294 including the testing, fitting or instruction in the use of such devices;  
295 [(F)] (E) other supplies or services prescribed by a physician for the  
296 rehabilitation of a patient and ordinarily furnished by a comprehensive  
297 rehabilitation facility.

298 (2) "Comprehensive rehabilitation facility" means a facility [which]  
299 that is: (A) Primarily engaged in providing diagnostic, therapeutic and  
300 restorative services through such licensed health care professionals to

301 injured, ill or disabled individuals solely on an outpatient basis and (B)  
302 accredited for the provision of such services by the Commission on  
303 Accreditation for Rehabilitation Facilities or the Professional Services  
304 Board of the American Speech-Language Hearing Association.

305 (b) Any insurance company, hospital or medical service corporation  
306 or health care center authorized to do the business of health insurance  
307 in this state shall offer to any individual, partnership, corporation or  
308 unincorporated association providing group health insurance coverage  
309 of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of  
310 section 38a-469 for its employees or members, a group hospital or  
311 medical service plan or contract providing coverage for expenses  
312 incurred for comprehensive rehabilitation services under such terms  
313 and conditions as are agreed to by the policyholder and the insurer.

314 Sec. 4. Section 38a-553 of the general statutes is repealed and the  
315 following is substituted in lieu thereof (*Effective January 1, 2009*):

316 All individual and all group comprehensive health care plans shall  
317 include minimum standard benefits as described in this section.

318 (a) Except as provided in subsections (b) and (c), minimum standard  
319 benefits shall be benefits, including coverage for catastrophic illness,  
320 with a lifetime maximum of one million dollars per individual, for  
321 reasonable charges or, when applicable, the allowance agreed upon  
322 between a provider and a carrier for charges actually incurred, for the  
323 following health care services, rendered to an individual covered by  
324 such plan for the diagnosis or treatment of nonoccupational disease or  
325 injury: (1) Hospital services; (2) professional services which are  
326 rendered by a physician or, at his direction, by a registered nurse,  
327 other than services for mental or dental conditions; (3) the diagnosis or  
328 treatment of mental conditions, in accordance with the minimum  
329 requirements established in section 38a-514 of the 2008 supplement to  
330 the general statutes, as amended by this act; (4) legend drugs requiring  
331 a prescription of a physician, advanced practice registered nurse or  
332 physician assistant; (5) services of a skilled nursing facility for not

333 more than one hundred twenty days in a calendar year, provided such  
334 services commence within fourteen days following a confinement of at  
335 least three consecutive days in a hospital for the same condition; (6)  
336 home health agency services, as defined by the commissioner, up to a  
337 maximum of one hundred eighty visits in a calendar year, provided  
338 such services commence within seven days following confinement in a  
339 hospital or skilled nursing facility of at least three consecutive days for  
340 the same condition, provided further, in the case of an individual  
341 diagnosed by a physician as terminally ill with a prognosis of six  
342 months or less to live, such home health agency services may  
343 commence irrespective of whether such covered person was so  
344 confined; [or, if such covered person was so confined, irrespective of  
345 such seven-day period, and the yearly benefit for medical social  
346 services, as hereinafter defined, shall not exceed two hundred dollars.  
347 "Medical social services" means services rendered, under the direction  
348 of a physician by a qualified social worker holding a master's degree  
349 from an accredited school of social work, including but not limited to  
350 (A) assessment of the social, psychological and family problems  
351 related to or arising out of such covered person's illness and treatment;  
352 (B) appropriate action and utilization of community resources to assist  
353 in resolving such problems; (C) participation in the development of  
354 treatment for such covered person;] (7) use of radium or other  
355 radioactive materials; (8) outpatient chemotherapy for the removal of  
356 tumors and treatment of leukemia, including outpatient  
357 chemotherapy; (9) oxygen; (10) anesthetics; (11) nondental prosthesis  
358 and maxillo-facial prosthesis used to replace any anatomic structure  
359 lost during treatment for head and neck tumors or additional  
360 appliances essential for the support of such prosthesis; (12) rental of  
361 durable medical equipment which has no personal use in the absence  
362 of the condition for which prescribed; (13) diagnostic x-rays and  
363 laboratory tests as defined by the commissioner; (14) oral surgery for:  
364 (A) Excision of partially or completely unerupted impacted teeth, or  
365 (B) excision of a tooth root without the extraction of the entire tooth;  
366 (15) services of a licensed physical therapist, rendered under the

367 direction of a physician; (16) transportation by a local professional  
368 ambulance to the nearest health care institution qualified to treat the  
369 illness or injury; (17) certain other services which are medically  
370 necessary in the treatment or diagnosis of an illness or injury as may be  
371 designated or approved by the Insurance Commissioner; (18)  
372 confinement in a facility established primarily for the treatment of  
373 alcoholism and licensed for such care by the state, or in a part of a  
374 hospital used primarily for such treatment, shall be a covered expense  
375 for a period of at least forty-five days within any calendar year.

376 (b) Minimum standard benefits may include one or more of the  
377 following provisions: (1) For policies issued or renewed prior to April  
378 1, 1994, subject to the provisions of subdivision (3) such plan may  
379 require deductibles. The "low option deductible" shall be two hundred  
380 dollars per person, the "middle option deductible" shall be five  
381 hundred dollars per person, and the "high option deductible" shall be  
382 seven hundred fifty dollars per person. The amount of the deductible  
383 may not be greater when a service is rendered on an outpatient basis  
384 than when that service is offered on an inpatient basis. Expenses  
385 incurred during the last three months of a calendar year and actually  
386 applied to an individual's deductible for that year shall be applied to  
387 that individual's deductible in the following calendar year. The two-  
388 hundred-dollar maximum, the five-hundred-dollar maximum and the  
389 seven-hundred-fifty-dollar maximum may be adjusted yearly to  
390 correspond with the change in the medical care component of the  
391 Consumer Price Index, as adjusted by the commissioner. The base year  
392 for such computation shall be the first full year of operation of such  
393 plan. (2) For policies issued or renewed prior to April 1, 1994, subject  
394 to the provisions of subdivision (3), such plan shall require a  
395 maximum copayment of twenty per cent for charges for all types of  
396 health care in excess of the deductible and fifty per cent for services  
397 listed in subdivision (3) of subsection (a) in excess of the deductible. (3)  
398 The sum of any deductible and copayments required in any calendar  
399 year may not exceed a maximum limit of one thousand dollars per  
400 covered individual, or two thousand dollars per covered family;

401 provided, covered expenses incurred after the applicable maximum  
402 limit has been reached shall be paid at the rate of one hundred per  
403 cent, except that expenses incurred for treatment of mental and  
404 nervous conditions may be paid at the rate of fifty per cent as specified  
405 in subdivision (3) of subsection (a). The one-thousand-dollar and two-  
406 thousand-dollar maximums shall be adjusted yearly to correspond  
407 with the change in the medical care component of the Consumer Price  
408 Index as adjusted by the commissioner. (4) The plan shall limit benefits  
409 with respect to each pregnancy, other than a pregnancy involving  
410 complications of pregnancy, to a maximum of two hundred fifty  
411 dollars. (5) The plan may limit lifetime benefits to a maximum of not  
412 less than one million dollars per covered individual. (6) No preexisting  
413 condition exclusion shall exclude coverage of any preexisting  
414 condition unless: (A) The condition first manifested itself within the  
415 period of six months immediately prior to the effective date of  
416 coverage in such a manner as would cause a reasonably prudent  
417 person to seek diagnosis, care or treatment; (B) medical advice or  
418 treatment was recommended or received within the period of six  
419 months immediately prior to the effective date of coverage; or (C) the  
420 condition is pregnancy existing on the effective date of coverage. No  
421 policy shall exclude coverage for a loss due to preexisting conditions  
422 for a period greater than twelve months following the effective date of  
423 coverage. Any individual comprehensive health care plan issued as a  
424 result of conversion from group health insurance or from a self-  
425 insured group shall credit the time covered under such group health  
426 insurance toward any such exclusion.

427 (c) Plans providing minimum standard benefits need not provide  
428 benefits for the following: (1) Any charge for any care for any injury or  
429 disease either (A) arising out of and in the course of an employment  
430 subject to a workers' compensation or similar law or where such  
431 benefit is required to be provided under a workers' compensation  
432 policy to a sole proprietor, business partner or corporation officer who  
433 elects such coverage pursuant to the provisions of chapter 568 or (B) to  
434 the extent benefits are payable without regard to fault under a

435 coverage statutorily required to be contained in any motor vehicle or  
436 other liability insurance policy or equivalent self-insurance; (2) any  
437 charge for treatment for cosmetic purposes other than surgery for the  
438 prompt repair of an accidental injury sustained while covered,  
439 provided cosmetic shall not mean replacement of any anatomic  
440 structure removed during treatment of tumors; (3) any charge for  
441 travel, other than transportation by local professional ambulance to the  
442 nearest health care institution qualified to treat the illness or injury; (4)  
443 any charge for private room accommodations to the extent it is in  
444 excess of the institution's most common charge for a semiprivate room;  
445 (5) any charge by health care institutions to the extent that it is  
446 determined by the carrier that the charge exceeds the rates approved  
447 by the Office of Health Care Access; (6) any charge for services or  
448 articles to the extent that it exceeds the reasonable charge in the locality  
449 for the service; (7) any charge for services or articles which are  
450 determined not to be medically necessary, except that this shall not  
451 apply to the fabrication or placement of the prosthesis as specified in  
452 subdivision (11) of subsection (a) of this section and subdivision (2) of  
453 this subsection; (8) any charge for services or articles the provisions of  
454 which is not within the scope of the license or certificate of the  
455 institution or individual rendering such services or articles; (9) any  
456 charge for services or articles furnished, paid for or reimbursed  
457 directly by or under any law of a government, except as otherwise  
458 provided herein; (10) any charge for services or articles for custodial  
459 care or designed primarily to assist an individual in meeting his  
460 activities of daily living; (11) any charge for services which would not  
461 have been made if no insurance existed or for which the covered  
462 individual is not legally obligated to pay; (12) any charge for  
463 eyeglasses, contact lenses or hearing aids or the fitting thereof; (13) any  
464 charge for dental care not specifically covered by sections 38a-505, 38a-  
465 546 and 38a-551 to 38a-559, inclusive; and (14) any charge for services  
466 of a registered nurse who ordinarily resides in the covered individual's  
467 home, or who is a member of the covered individual's family or the  
468 family of the covered individual's spouse.

469 (d) and (e) Repealed by P.A. 84-499, S. 2.

470 (f) The minimum standard benefits of any individual or group  
471 comprehensive health care plan may be satisfied by catastrophic  
472 coverage offered in conjunction with basic hospital or medical-surgical  
473 plans on an expense incurred or service basis as approved by the  
474 commissioner as providing at least equivalent benefits.

475 (g) Comprehensive health care plan carriers may offer alternative  
476 policy provisions and benefits, including cost containment features,  
477 consistent with the purposes of sections 38a-505, 38a-546 and 38a-551  
478 to 38a-559, inclusive, provided such alternative provisions and benefits  
479 are approved by the Insurance Commissioner prior to their use. Cost  
480 containment features may include, but shall not be limited to,  
481 preferred provider provisions; utilization review of health care  
482 services, including review of the medical necessity of hospital and  
483 physician services; case management benefit alternatives; and other  
484 managed care provisions.

485 (h) Every comprehensive health care plan issued or renewed  
486 through the Health Reinsurance Association on or after April 1, 1994,  
487 shall be a managed care plan. Such managed care plans shall include  
488 one or more health care center plans or preferred provider network  
489 plans, as determined by the board of the association, with the approval  
490 of the commissioner. In the event that such managed care plans would  
491 not adequately serve enrollees in a particular area of the state, the  
492 board may offer to such enrollees a managed care product which  
493 contains alternative cost containment features, including but not  
494 limited to, utilization review of health care services, review of the  
495 medical necessity of hospital and physician services and case  
496 management benefit alternatives.

497 (i) No comprehensive health care plan issued through the Health  
498 Reinsurance Association to a HIPAA eligible individual shall include  
499 any limitation or exclusion of benefits based on a preexisting  
500 condition.

501 (j) No comprehensive health care plan issued through the Health  
502 Reinsurance Association to a health care tax credit eligible individual  
503 shall include any limitation or exclusion of benefit based on a  
504 preexisting condition if such individual maintained creditable health  
505 insurance coverage for an aggregate period of three months as of the  
506 date on which the individual seeks to enroll in the Health Reinsurance  
507 Association issued plan, not counting any period prior to a sixty-three-  
508 day break in coverage.

509 (k) (1) Each comprehensive health care plan issued through the  
510 Health Reinsurance Association shall provide coverage, under the  
511 terms and conditions of the plan, for the preexisting conditions of any  
512 group member or dependent who is newly insured under the plan on  
513 or after October 1, 2005, and was previously covered for such  
514 preexisting condition under the terms of the group member's or  
515 dependent's preceding qualifying coverage, provided the preceding  
516 qualifying coverage was continuous to a date less than one hundred  
517 twenty days prior to the effective date of the new coverage, exclusive  
518 of any applicable waiting period, except in the case of a newly insured  
519 group member whose preceding qualifying coverage was terminated  
520 due to an involuntary loss of employment, the preceding qualifying  
521 coverage must have been continuous to a date not more than one  
522 hundred fifty days prior to the effective date of the new coverage  
523 under the plan, exclusive of any applicable waiting period, provided  
524 the requirements of this subdivision shall only apply if the newly  
525 insured group member or dependent applies for such succeeding  
526 coverage not later than thirty days after the first day of the member's  
527 or dependent's initial eligibility.

528 (2) With respect to a group member or dependent who was newly  
529 insured under the plan on or after October 1, 2005, and was previously  
530 covered under qualifying coverage, but was not covered under such  
531 qualifying coverage for a preexisting condition, as defined under the  
532 newly issued comprehensive health care plan, such plan shall credit  
533 the time such group member or dependent was previously covered by

534 qualifying coverage to the exclusion period of the preexisting  
 535 condition provision, provided the preceding qualifying coverage was  
 536 continuous to a date less than one hundred twenty days prior to the  
 537 effective date of the new coverage, exclusive of any applicable waiting  
 538 period under such plan, except in the case of a newly insured group  
 539 member whose preceding qualifying coverage was terminated due to  
 540 an involuntary loss of employment, the preceding qualifying coverage  
 541 must have been continuous to a date not more than one hundred fifty  
 542 days prior to the effective date of the new coverage, exclusive of any  
 543 applicable waiting period, provided the requirements of this  
 544 subdivision shall only apply if such newly insured group member or  
 545 dependent applies for such succeeding coverage not later than thirty  
 546 days after the first day of the member's or dependent's initial  
 547 eligibility.

548 (3) As used in this subsection, "qualifying coverage" means coverage  
 549 under (A) any group health insurance plan, group insurance  
 550 arrangement or self-insured plan covering a group, (B) Medicare or  
 551 Medicaid, or (C) an individual health insurance plan that provides  
 552 benefits which are actuarially equivalent to or exceeding the benefits  
 553 provided under a small employer health care plan, as defined in  
 554 section 38a-564 of the 2008 supplement to the general statutes, whether  
 555 issued in this state or any other state, as determined by the Insurance  
 556 Department.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2009</i>	38a-488a
Sec. 2	<i>January 1, 2009</i>	38a-514
Sec. 3	<i>January 1, 2009</i>	38a-523
Sec. 4	<i>January 1, 2009</i>	38a-553

**Statement of Purpose:**

To reduce the cost of health insurance by removing certain mandates.

*[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]*