



Senate

General Assembly

File No. 449

January Session, 2015

Senate Bill No. 1085

Senate, April 2, 2015

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR MENTAL OR NERVOUS CONDITIONS.

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

1 Section 1. Section 38a-488a of the general statutes is repealed and
2 the following is substituted in lieu thereof (*Effective January 1, 2016*):

3 (a) [Each individual health insurance policy providing coverage of
4 the type specified in subdivisions (1), (2), (4), (11) and (12) of section
5 38a-469 delivered, issued for delivery, renewed, amended or continued
6 in this state shall provide benefits for the diagnosis and treatment of
7 mental or nervous conditions.] For the purposes of this section: [,
8 "mental or nervous conditions"] (1) "Mental or nervous conditions"
9 means mental disorders, as defined in the most recent edition of the
10 American Psychiatric Association's "Diagnostic and Statistical Manual
11 of Mental Disorders". "Mental or nervous conditions" does not include
12 [(1)] (A) intellectual disabilities, [(2)] (B) specific learning disorders,
13 [(3)] (C) motor disorders, [(4)] (D) communication disorders, [(5)] (E)
14 caffeine-related disorders, [(6)] (F) relational problems, and [(7)] (G)

15 other conditions that may be a focus of clinical attention, that are not
16 otherwise defined as mental disorders in the most recent edition of the
17 American Psychiatric Association's "Diagnostic and Statistical Manual
18 of Mental Disorders"; [, except that coverage for an insured under such
19 policy who has been diagnosed with autism spectrum disorder prior to
20 the release of the fifth edition of the American Psychiatric Association's
21 "Diagnostic and Statistical Manual of Mental Disorders" shall be
22 provided in accordance with subsection (b) of section 38a-488b.] (2)
23 "benefits payable" means the usual, customary and reasonable charges
24 for treatment deemed necessary under generally accepted medical
25 standards, except that in the case of a managed care plan, as defined in
26 section 38a-478, "benefits payable" means the payments agreed upon in
27 the contract between a managed care organization, as defined in
28 section 38a-478, and a provider, as defined in section 38a-478; (3) "acute
29 treatment services" means twenty-four-hour medically supervised
30 treatment for a substance use disorder, that is provided in a medically
31 managed or medically monitored inpatient facility; and (4) "clinical
32 stabilization services" means twenty-four-hour clinically managed
33 postdetoxification treatment, including, but not limited to, relapse
34 prevention, family outreach, aftercare planning and addiction
35 education and counseling.

36 (b) (1) Each individual health insurance policy providing coverage
37 of the type specified in subdivisions (1), (2), (4), (11) and (12) of section
38 38a-469 delivered, issued for delivery, renewed, amended or continued
39 in this state shall provide benefits for the diagnosis and treatment of
40 mental or nervous conditions. Benefits payable include, but need not
41 be limited to:

42 (A) General inpatient hospitalization, including in state-operated
43 facilities, without prior authorization for up to fourteen days of
44 inpatient hospital treatment for acute treatment services and clinical
45 stabilization services;

46 (B) Medically necessary acute treatment services and medically
47 necessary clinical stabilization services without prior authorization for

48 up to fourteen days;

49 (C) General hospital outpatient services, including at state-operated
50 facilities;

51 (D) Psychiatric inpatient hospitalization, including in state-operated
52 facilities;

53 (E) Psychiatric outpatient hospital services, including at state-
54 operated facilities;

55 (F) Intensive outpatient services, including at state-operated
56 facilities;

57 (G) Partial hospitalization, including at state-operated facilities;

58 (H) Evidence-based maternal, infant and early childhood home
59 visitation services, as described in Section 2951 of the Patient
60 Protection and Affordable Care Act, P.L. 111-148, as amended from
61 time to time, that are designed to improve health outcomes for
62 pregnant women, postpartum mothers and newborns and children,
63 including, but not limited to, for maternal substance use disorders or
64 depression and relationship-focused interventions for children with
65 mental or nervous conditions or substance use disorders;

66 (I) Intensive, home-based services designed to address specific
67 mental or nervous conditions in a child while remediating problematic
68 parenting practices and addressing other family and educational
69 challenges that affect the child's and family's ability to function;

70 (J) Intensive, family-based and community-based treatment
71 programs that focus on addressing environmental systems that impact
72 chronic and violent juvenile offenders;

73 (K) Evidence-based family-focused therapy that specializes in the
74 treatment of juvenile substance use disorders and delinquency;

75 (L) Short-term family therapy intervention and juvenile diversion
76 programs that target at-risk children to address adolescent behavior

- 77 problems, conduct disorders, substance use disorders and
78 delinquency;
- 79 (M) Other home-based therapeutic interventions for children;
- 80 (N) Chemical maintenance treatment, as defined in section 19a-495-
81 570 of the regulations of Connecticut state agencies;
- 82 (O) Nonhospital inpatient detoxification;
- 83 (P) Medically monitored detoxification;
- 84 (Q) Ambulatory detoxification;
- 85 (R) Inpatient services at psychiatric residential treatment facilities;
- 86 (S) Extended day treatment programs, as described in section 17a-
87 22;
- 88 (T) Rehabilitation services provided in a licensed group home or in
89 a community-based setting;
- 90 (U) Rehabilitation services provided in residential treatment
91 facilities;
- 92 (V) Observation beds in acute hospital settings;
- 93 (W) Emergency mobile psychiatric services;
- 94 (X) Case management conducted by a licensed health care provider,
95 including care coordination, communication and treatment planning
96 with other health care providers, necessary to ensure adequate and
97 appropriate treatment for a diagnosed mental or nervous condition;
- 98 (Y) Psychological and neuropsychological testing conducted by an
99 appropriately licensed health care provider;
- 100 (Z) Trauma screening conducted by a licensed behavioral health
101 professional;

102 (AA) Depression screening, including maternal depression
103 screening, conducted by a licensed behavioral health professional; and

104 (BB) Substance use screening conducted by a licensed behavioral
105 health professional.

106 (2) With respect to the benefits required under subparagraphs (A)
107 and (B) of subdivision (1) of this subsection, the facility at which such
108 hospitalization or treatment is provided shall, not later than forty-eight
109 hours after the insured's admission for such hospitalization or
110 treatment, notify the issuer of the policy of such admission and
111 provide an initial treatment plan to such issuer. Such issuer may
112 initiate utilization review procedures for such hospitalization or
113 treatment on or after the seventh day after such hospitalization or
114 treatment commences.

115 [(b)] (c) No such policy shall establish any terms, conditions or
116 benefits that place a greater financial burden on an insured for access
117 to diagnosis or treatment of mental or nervous conditions than for
118 diagnosis or treatment of medical, surgical or other physical health
119 conditions, or prohibit an insured from obtaining or a health care
120 provider from being reimbursed for multiple screening services as part
121 of a single-day visit to a health care provider or a multicare institution,
122 as defined in section 19a-490.

123 [(c)] (d) In the case of benefits payable for the services of a licensed
124 physician, such benefits shall be payable for the same services when
125 such services are lawfully rendered by a psychologist licensed under
126 the provisions of chapter 383 or by such a licensed psychologist in a
127 licensed hospital or clinic.

128 [(d)] (e) In the case of benefits payable for the services of a licensed
129 physician or psychologist, such benefits shall be payable for the same
130 services when such services are rendered by:

131 (1) A clinical social worker who is licensed under the provisions of
132 chapter 383b and who has passed the clinical examination of the

133 American Association of State Social Work Boards and has completed
134 at least two thousand hours of post-master's social work experience in
135 a nonprofit agency qualifying as a tax-exempt organization under
136 Section 501(c) of the Internal Revenue Code of 1986 or any subsequent
137 corresponding internal revenue code of the United States, as from time
138 to time amended, in a municipal, state or federal agency or in an
139 institution licensed by the Department of Public Health under section
140 19a-490;

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

143 (3) A licensed marital and family therapist who has completed at
144 least two thousand hours of post-master's marriage and family therapy
145 work experience in a nonprofit agency qualifying as a tax-exempt
146 organization under Section 501(c) of the Internal Revenue Code of 1986
147 or any subsequent corresponding internal revenue code of the United
148 States, as from time to time amended, in a municipal, state or federal
149 agency or in an institution licensed by the Department of Public Health
150 under section 19a-490;

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

153 (5) A licensed alcohol and drug counselor, as defined in section 20-
154 74s, or a certified alcohol and drug counselor, as defined in section 20-
155 74s; [or]

156 (6) A licensed professional counselor; or

157 (7) An advanced practice registered nurse licensed under chapter
158 378.

159 [(e) For purposes of this section, the term "covered expenses" means
160 the usual, customary and reasonable charges for treatment deemed
161 necessary under generally accepted medical standards, except that in
162 the case of a managed care plan, as defined in section 38a-478,
163 "covered expenses" means the payments agreed upon in the contract

164 between a managed care organization, as defined in section 38a-478,
165 and a provider, as defined in section 38a-478.]

166 (f) (1) In the case of benefits payable for the services of a licensed
167 physician, such benefits shall be payable for (A) services rendered in a
168 child guidance clinic or residential treatment facility by a person with a
169 master's degree in social work or by a person with a master's degree in
170 marriage and family therapy under the supervision of a psychiatrist,
171 physician, licensed marital and family therapist, or licensed clinical
172 social worker who is eligible for reimbursement under subdivisions (1)
173 to (4), inclusive, of subsection [(d)] (e) of this section; (B) services
174 rendered in a residential treatment facility by a licensed or certified
175 alcohol and drug counselor who is eligible for reimbursement under
176 subdivision (5) of subsection [(d)] (e) of this section; or (C) services
177 rendered in a residential treatment facility by a licensed professional
178 counselor who is eligible for reimbursement under subdivision (6) of
179 subsection [(d)] (e) of this section.

180 (2) In the case of benefits payable for the services of a licensed
181 psychologist under subsection [(d)] (e) of this section, such benefits
182 shall be payable for (A) services rendered in a child guidance clinic or
183 residential treatment facility by a person with a master's degree in
184 social work or by a person with a master's degree in marriage and
185 family therapy under the supervision of such licensed psychologist,
186 licensed marital and family therapist, or licensed clinical social worker
187 who is eligible for reimbursement under subdivisions (1) to (4),
188 inclusive, of subsection [(d)] (e) of this section; (B) services rendered in
189 a residential treatment facility by a licensed or certified alcohol and
190 drug counselor who is eligible for reimbursement under subdivision
191 (5) of subsection [(d)] (e) of this section; or (C) services rendered in a
192 residential treatment facility by a licensed professional counselor who
193 is eligible for reimbursement under subdivision (6) of subsection [(d)]
194 (e) of this section.

195 (g) In the case of benefits payable for the service of a licensed
196 physician practicing as a psychiatrist or a licensed psychologist, under

197 subsection [(d)] (e) of this section, such benefits shall be payable for
198 outpatient services rendered (1) in a nonprofit community mental
199 health center, as defined by the Department of Mental Health and
200 Addiction Services, in a nonprofit licensed adult psychiatric clinic
201 operated by an accredited hospital or in a residential treatment facility;
202 (2) under the supervision of a licensed physician practicing as a
203 psychiatrist, a licensed psychologist, a licensed marital and family
204 therapist, a licensed clinical social worker, a licensed or certified
205 alcohol and drug counselor or a licensed professional counselor who is
206 eligible for reimbursement under subdivisions (1) to (6), inclusive, of
207 subsection [(d)] (e) of this section; and (3) within the scope of the
208 license issued to the center or clinic by the Department of Public
209 Health or to the residential treatment facility by the Department of
210 Children and Families.

211 (h) Except in the case of emergency services or in the case of services
212 for which an individual has been referred by a physician affiliated
213 with a health care center, nothing in this section shall be construed to
214 require a health care center to provide benefits under this section
215 through facilities that are not affiliated with the health care center.

216 (i) In the case of any person admitted to a state institution or facility
217 administered by the Department of Mental Health and Addiction
218 Services, Department of Public Health, Department of Children and
219 Families or the Department of Developmental Services, the state shall
220 have a lien upon the proceeds of any coverage available to such person
221 or a legally liable relative of such person under the terms of this
222 section, to the extent of the per capita cost of such person's care. Except
223 in the case of emergency services, the provisions of this subsection
224 shall not apply to coverage provided under a managed care plan, as
225 defined in section 38a-478.

226 Sec. 2. Section 38a-514 of the general statutes is repealed and the
227 following is substituted in lieu thereof (*Effective January 1, 2016*):

228 (a) [Except as provided in subsection (j) of this section, each group
229 health insurance policy, providing coverage of the type specified in

230 subdivisions (1), (2), (4), (11) and (12) of section 38a-469, delivered,
231 issued for delivery, renewed, amended or continued in this state shall
232 provide benefits for the diagnosis and treatment of mental or nervous
233 conditions.] For the purposes of this section: [, "mental or nervous
234 conditions"] (1) "Mental or nervous conditions" means mental
235 disorders, as defined in the most recent edition of the American
236 Psychiatric Association's "Diagnostic and Statistical Manual of Mental
237 Disorders". "Mental or nervous conditions" does not include [(1)] (A)
238 intellectual disabilities, [(2)] (B) specific learning disorders, [(3)] (C)
239 motor disorders, [(4)] (D) communication disorders, [(5)] (E) caffeine-
240 related disorders, [(6)] (F) relational problems, and [(7)] (G) other
241 conditions that may be a focus of clinical attention, that are not
242 otherwise defined as mental disorders in the most recent edition of the
243 American Psychiatric Association's "Diagnostic and Statistical Manual
244 of Mental Disorders"; [, except that coverage for an insured under such
245 policy who has been diagnosed with autism spectrum disorder prior to
246 the release of the fifth edition of the American Psychiatric Association's
247 "Diagnostic and Statistical Manual of Mental Disorders" shall be
248 provided in accordance with subsection (i) of section 38a-514b.] (2)
249 "benefits payable" means the usual, customary and reasonable charges
250 for treatment deemed necessary under generally accepted medical
251 standards, except that in the case of a managed care plan, as defined in
252 section 38a-478, "benefits payable" means the payments agreed upon in
253 the contract between a managed care organization, as defined in
254 section 38a-478, and a provider, as defined in section 38a-478; (3) "acute
255 treatment services" means twenty-four-hour medically supervised
256 treatment for a substance use disorder, that is provided in a medically
257 managed or medically monitored inpatient facility; and (4) "clinical
258 stabilization services" means twenty-four-hour clinically managed
259 postdetoxification treatment, including, but not limited to, relapse
260 prevention, family outreach, aftercare planning and addiction
261 education and counseling.

262 (b) (1) Except as provided in subsection (j) of this section, each
263 group health insurance policy, providing coverage of the type
264 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469,

265 delivered, issued for delivery, renewed, amended or continued in this
266 state shall provide benefits for the diagnosis and treatment of mental
267 or nervous conditions. Benefits payable include, but need not be
268 limited to:

269 (A) General inpatient hospitalization, including in state-operated
270 facilities, without prior authorization for up to fourteen days of
271 inpatient hospital treatment for acute treatment services and clinical
272 stabilization services;

273 (B) Medically necessary acute treatment services and medically
274 necessary clinical stabilization services without prior authorization for
275 up to fourteen days;

276 (C) General hospital outpatient services, including at state-operated
277 facilities;

278 (D) Psychiatric inpatient hospitalization, including in state-operated
279 facilities;

280 (E) Psychiatric outpatient hospital services, including at state-
281 operated facilities;

282 (F) Intensive outpatient services, including at state-operated
283 facilities;

284 (G) Partial hospitalization, including at state-operated facilities;

285 (H) Evidence-based maternal, infant and early childhood home
286 visitation services, as described in Section 2951 of the Patient
287 Protection and Affordable Care Act, P.L. 111-148, as amended from
288 time to time, that are designed to improve health outcomes for
289 pregnant women, postpartum mothers and newborns and children,
290 including, but not limited to, for maternal substance use disorders or
291 depression and relationship-focused interventions for children with
292 mental or nervous conditions or substance use disorders;

293 (I) Intensive, home-based services designed to address specific

294 mental or nervous conditions in a child while remediating problematic
295 parenting practices and addressing other family and educational
296 challenges that affect the child's and family's ability to function;

297 (J) Intensive, family-based and community-based treatment
298 programs that focus on addressing environmental systems that impact
299 chronic and violent juvenile offenders;

300 (K) Evidence-based family-focused therapy that specializes in the
301 treatment of juvenile substance use disorders and delinquency;

302 (L) Short-term family therapy intervention and juvenile diversion
303 programs that target at-risk children to address adolescent behavior
304 problems, conduct disorders, substance use disorders and
305 delinquency;

306 (M) Other home-based therapeutic interventions for children;

307 (N) Chemical maintenance treatment, as defined in section 19a-495-
308 570 of the regulations of Connecticut state agencies;

309 (O) Nonhospital inpatient detoxification;

310 (P) Medically monitored detoxification;

311 (Q) Ambulatory detoxification;

312 (R) Inpatient services at psychiatric residential treatment facilities;

313 (S) Extended day treatment programs, as described in section 17a-
314 22;

315 (T) Rehabilitation services provided in a licensed group home or in
316 a community-based setting;

317 (U) Rehabilitation services provided in residential treatment
318 facilities;

319 (V) Observation beds in acute hospital settings;

320 (W) Emergency mobile psychiatric services;

321 (X) Case management conducted by a licensed health care provider,
322 including care coordination, communication and treatment planning
323 with other health care providers, necessary to ensure adequate and
324 appropriate treatment for a diagnosed mental or nervous condition;

325 (Y) Psychological and neuropsychological testing conducted by an
326 appropriately licensed health care provider;

327 (Z) Trauma screening conducted by a licensed behavioral health
328 professional;

329 (AA) Depression screening, including maternal depression
330 screening, conducted by a licensed behavioral health professional; and

331 (BB) Substance use screening conducted by a licensed behavioral
332 health professional.

333 (2) With respect to the benefits required under subparagraphs (A)
334 and (B) of subdivision (1) of this subsection, the facility at which such
335 hospitalization or treatment is provided shall, not later than forty-eight
336 hours after the insured's admission for such hospitalization or
337 treatment, notify the issuer of the policy of such admission and
338 provide an initial treatment plan to such issuer. Such issuer may
339 initiate utilization review procedures for such hospitalization or
340 treatment on or after the seventh day after such hospitalization or
341 treatment commences.

342 [(b)] (c) No such group policy shall establish any terms, conditions
343 or benefits that place a greater financial burden on an insured for
344 access to diagnosis or treatment of mental or nervous conditions than
345 for diagnosis or treatment of medical, surgical or other physical health
346 conditions, or prohibit an insured from obtaining or a health care
347 provider from being reimbursed for multiple screening services as part
348 of a single-day visit to a health care provider or a multicare institution,
349 as defined in section 19a-490.

350 [(c)] (d) In the case of benefits payable for the services of a licensed
351 physician, such benefits shall be payable for the same services when
352 such services are lawfully rendered by a psychologist licensed under
353 the provisions of chapter 383 or by such a licensed psychologist in a
354 licensed hospital or clinic.

355 [(d)] (e) In the case of benefits payable for the services of a licensed
356 physician or psychologist, such benefits shall be payable for the same
357 services when such services are rendered by:

358 (1) A clinical social worker who is licensed under the provisions of
359 chapter 383b and who has passed the clinical examination of the
360 American Association of State Social Work Boards and has completed
361 at least two thousand hours of post-master's social work experience in
362 a nonprofit agency qualifying as a tax-exempt organization under
363 Section 501(c) of the Internal Revenue Code of 1986 or any subsequent
364 corresponding internal revenue code of the United States, as from time
365 to time amended, in a municipal, state or federal agency or in an
366 institution licensed by the Department of Public Health under section
367 19a-490;

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

370 (3) A licensed marital and family therapist who has completed at
371 least two thousand hours of post-master's marriage and family therapy
372 work experience in a nonprofit agency qualifying as a tax-exempt
373 organization under Section 501(c) of the Internal Revenue Code of 1986
374 or any subsequent corresponding internal revenue code of the United
375 States, as from time to time amended, in a municipal, state or federal
376 agency or in an institution licensed by the Department of Public Health
377 under section 19a-490;

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

380 (5) A licensed alcohol and drug counselor, as defined in section 20-

381 74s, or a certified alcohol and drug counselor, as defined in section 20-
382 74s; [or]

383 (6) A licensed professional counselor; or

384 (7) An advanced practice registered nurse licensed under chapter
385 378.

386 [(e) For purposes of this section, the term "covered expenses" means
387 the usual, customary and reasonable charges for treatment deemed
388 necessary under generally accepted medical standards, except that in
389 the case of a managed care plan, as defined in section 38a-478,
390 "covered expenses" means the payments agreed upon in the contract
391 between a managed care organization, as defined in section 38a-478,
392 and a provider, as defined in section 38a-478.]

393 (f) (1) In the case of benefits payable for the services of a licensed
394 physician, such benefits shall be payable for (A) services rendered in a
395 child guidance clinic or residential treatment facility by a person with a
396 master's degree in social work or by a person with a master's degree in
397 marriage and family therapy under the supervision of a psychiatrist,
398 physician, licensed marital and family therapist or licensed clinical
399 social worker who is eligible for reimbursement under subdivisions (1)
400 to (4), inclusive, of subsection [(d)] (e) of this section; (B) services
401 rendered in a residential treatment facility by a licensed or certified
402 alcohol and drug counselor who is eligible for reimbursement under
403 subdivision (5) of subsection [(d)] (e) of this section; or (C) services
404 rendered in a residential treatment facility by a licensed professional
405 counselor who is eligible for reimbursement under subdivision (6) of
406 subsection [(d)] (e) of this section.

407 (2) In the case of benefits payable for the services of a licensed
408 psychologist under subsection [(d)] (e) of this section, such benefits
409 shall be payable for (A) services rendered in a child guidance clinic or
410 residential treatment facility by a person with a master's degree in
411 social work or by a person with a master's degree in marriage and
412 family therapy under the supervision of such licensed psychologist,

413 licensed marital and family therapist or licensed clinical social worker
414 who is eligible for reimbursement under subdivisions (1) to (4),
415 inclusive, of subsection [(d)] (e) of this section; (B) services rendered in
416 a residential treatment facility by a licensed or certified alcohol and
417 drug counselor who is eligible for reimbursement under subdivision
418 (5) of subsection [(d)] (e) of this section; or (C) services rendered in a
419 residential treatment facility by a licensed professional counselor who
420 is eligible for reimbursement under subdivision (6) of subsection [(d)]
421 (e) of this section.

422 (g) In the case of benefits payable for the service of a licensed
423 physician practicing as a psychiatrist or a licensed psychologist, under
424 subsection [(d)] (e) of this section, such benefits shall be payable for
425 outpatient services rendered (1) in a nonprofit community mental
426 health center, as defined by the Department of Mental Health and
427 Addiction Services, in a nonprofit licensed adult psychiatric clinic
428 operated by an accredited hospital or in a residential treatment facility;
429 (2) under the supervision of a licensed physician practicing as a
430 psychiatrist, a licensed psychologist, a licensed marital and family
431 therapist, a licensed clinical social worker, a licensed or certified
432 alcohol and drug counselor, or a licensed professional counselor who
433 is eligible for reimbursement under subdivisions (1) to (6), inclusive, of
434 subsection [(d)] (e) of this section; and (3) within the scope of the
435 license issued to the center or clinic by the Department of Public
436 Health or to the residential treatment facility by the Department of
437 Children and Families.

438 (h) Except in the case of emergency services or in the case of services
439 for which an individual has been referred by a physician affiliated
440 with a health care center, nothing in this section shall be construed to
441 require a health care center to provide benefits under this section
442 through facilities that are not affiliated with the health care center.

443 (i) In the case of any person admitted to a state institution or facility
444 administered by the Department of Mental Health and Addiction
445 Services, Department of Public Health, Department of Children and

446 Families or the Department of Developmental Services, the state shall
447 have a lien upon the proceeds of any coverage available to such person
448 or a legally liable relative of such person under the terms of this
449 section, to the extent of the per capita cost of such person's care. Except
450 in the case of emergency services the provisions of this subsection shall
451 not apply to coverage provided under a managed care plan, as defined
452 in section 38a-478.

453 (j) A group health insurance policy may exclude the benefits
454 required by this section if such benefits are included in a separate
455 policy issued to the same group by an insurance company, health care
456 center, hospital service corporation, medical service corporation or
457 fraternal benefit society. Such separate policy, which shall include the
458 benefits required by this section and the benefits required by section
459 38a-533, shall not be required to include any other benefits mandated
460 by this title.

461 (k) In the case of benefits based upon confinement in a residential
462 treatment facility, such benefits shall be payable in situations in which
463 the insured has a serious mental or nervous condition that
464 substantially impairs the insured's thoughts, perception of reality,
465 emotional process or judgment or grossly impairs the behavior of the
466 insured, and, upon an assessment of the insured by a physician,
467 psychiatrist, psychologist or clinical social worker, cannot
468 appropriately, safely or effectively be treated in an acute care, partial
469 hospitalization, intensive outpatient or outpatient setting.

470 (l) The services rendered for which benefits are to be paid for
471 confinement in a residential treatment facility shall be based on an
472 individual treatment plan. For purposes of this section, the term
473 "individual treatment plan" means a treatment plan prescribed by a
474 physician with specific attainable goals and objectives appropriate to
475 both the patient and the treatment modality of the program.

This act shall take effect as follows and shall amend the following sections:

Section 1	<i>January 1, 2016</i>	38a-488a
Sec. 2	<i>January 1, 2016</i>	38a-514

INS *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 16 \$	FY 17 \$
State Comptroller - Fringe Benefits (State Employee Active and Retiree Health Accounts)	GF, TF - Cost	See Below	See Below
The State	Cost	See Below	See Below

Note: GF=General Fund and TF = Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 16 \$	FY 17 \$
Various Municipalities	STATE MANDATE - Cost	See Below	See Below

Explanation

The bill will result in a cost to the state employee and retiree health plan¹, municipalities, and the state, related to expanding the scope of mental health services required to be covered. The state plan provides coverage for many of the services specified in the bill and requires prior authorization for all covered services except for psychological and neuropsychological testing, trauma, depression, and substance use screenings. In general, the state plan does not provide coverage for the following services: treatment in a group-home, emergency mobile psychiatric services, or case management. Secondly, the bill requires coverage for inpatient hospitalization and medically necessary acute treatment and clinical stabilization services for up to 14 days without prior authorization. The state plan currently provides coverage for

¹ The state employee and retiree health plan is a self-insured health plan. Pursuant to federal law, self-insured health plans are exempt from state health mandates. However, the state has traditionally adopted all state health mandates.

inpatient hospitalization and clinical stabilization, but requires prior authorization for coverage. The bill also requires coverage for multiple screening services as part of a single visit to a provider or multicare institution. Lastly, the bill requires coverage of services for mental and nervous conditions provided by an APRN, which is not anticipated to result in a fiscal impact.

The cost to the state to expand coverage to include those services not currently covered will result in the following:

- Treatment in group homes will cost approximately \$550,000 in FY 16 and \$1.1 million in FY 17²;
- Emergency Mobile Psychiatric Services will depend on the rate negotiated for the private plan and the utilization of services;
- Case management will depend on the rate negotiated for the private plan and the utilization of services. The average rate for the state's public programs is approximately \$10.50 per 15 minute interval;
- Up to 14 day inpatient hospitalization, medically necessary acute treatment services, and medically necessary clinical stabilization services without prior authorization will depend on the extent to which care is provided that otherwise would not have been provided under the current prior authorization requirements. For reference the state health plan spent approximately \$13.8 million in FY 14 on inpatient mental health and substance use services. Inpatient hospitalization represented \$9 million. Each 2% increase in inpatient hospitalization is approximately \$180,000; and
- To the extent that multiple screenings, for a single visit, are

² Estimate is based on FY 14 paid claims experience for coverage provided for the state health plan by Oxford and assumes a per member per month (PMPM) of \$0.51 for the portion of the state plan population covered by Anthem.

billed separately, as opposed to being bundled into a single payment for the episode, there will be an additional cost to the state plan of approximately \$25,000 in FY 16 and \$50,000 in FY 17.³

Lastly, the cost to the state pursuant to the federal Affordable Care Act (ACA) (See Background) will depend on which services are determined to be expanded services. Current law requires health plans to cover the diagnosis of and treatment for mental and nervous conditions on the same basis as for medical, surgical, or other physical conditions, but does not specify the services in the same manner as the bill.

Municipal Impact

As previously stated, the bill may increase costs to certain fully insured municipal plans which do not provide coverage for the services enumerated in the bill or not to the extent required by the bill. The coverage requirements may result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2016. In addition, many municipal health plans are recognized as “grandfathered” health plans under the ACA.⁴ It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA. Pursuant to federal law, self-insured health plans are exempt from state health mandates.

Background: The State and the federal ACA

Lastly, the ACA requires that, the state’s health exchange’s qualified health plans (QHPs)⁵, include a federally defined essential health

³ The estimated cost is based on the PMPM impact of \$0.02. The cost estimate for the state employee plan is based on the plan membership as of January 2015.

⁴ Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010.

⁵ The state’s health exchange, Access Health CT, opened its marketplace for Connecticut residents to purchase QHPs from carriers, with coverage starting January 1, 2014.

benefits package (EHB). The federal government is allowing states to choose a benchmark plan⁶ to serve as the EHB until 2016 when the federal government is anticipated to revisit the EHB.

While states are allowed to mandate benefits in excess of the EHB, the federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the exchange, by reimbursing the carrier or the insured for the excess coverage. State mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB for 2014-2015 unless they are already part of the benchmark plan.⁷ However, neither the agency nor the mechanism for the state to pay these costs has been established.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to (1) medical inflation, (2) the number of members in the state and municipal health plans, and exchange health plans, and (3) the utilization of services.

*Sources: State of Connecticut Benefit Plan Document as of January 1, 2015
Office of the State Comptroller
Dept. of Social Services Website (Public Program Reimbursement Rates)*

⁶ The state's benchmark plan is the Connecticare HMO plan with supplemental coverage for pediatric dental and vision care as required by the ACA.

⁷ Source: Dept. of Health and Human Services. *Frequently Asked Questions on Essential Health Benefits Bulletin* (February 21, 2012).

OLR Bill Analysis**SB 1085*****AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR MENTAL OR NERVOUS CONDITIONS.*****SUMMARY:**

This bill expands the services certain health insurance policies must cover for mental and nervous conditions (see BACKGROUND). By law, a policy must cover the diagnosis of and treatment for mental or nervous conditions on the same basis as for medical, surgical, or other physical conditions (i.e., parity).

The bill requires insurers to cover, among other things:

1. certain acute (e.g., substance use disorder) treatment and clinical stabilization (e.g., postdetoxification) services for up to 14 days without preauthorization;
2. services provided by advanced practice registered nurses (APRNs) for mental and nervous conditions; and
3. programs to improve health outcomes for mothers, children, and families.

Under the bill, a policy cannot prohibit an insured from getting, or a provider getting reimbursed for, multiple screening services as part of a single-day visit to a health care provider or multicare institution (e.g., hospital, psychiatric outpatient clinic, or free standing facility for substance use treatment).

The bill substitutes the term “benefits payable” for “covered expenses” as it pertains to the mental or nervous conditions coverage provisions. By law, these are the usual, customary, and reasonable charges for medically necessary treatment or, in the case of a managed

care plan, the contracted rates.

The bill also makes technical and conforming changes.

The bill applies to individual and group health insurance policies issued, delivered, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, or (4) hospital or medical services, including those provided through an HMO. Due to the federal Employee Retirement Income Security Act, state insurance mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2016

COVERAGE FOR MENTAL OR NERVOUS CONDITIONS

Under the bill, insurers' coverage for mental or nervous conditions must include:

1. general hospital outpatient services,
2. psychiatric inpatient hospitalization and outpatient hospital services,
3. intensive outpatient services, and
4. partial hospitalization.

The bill specifies that these services may be provided at state-operated facilities.

The bill requires insurers to also cover:

1. evidence based maternal, infant, and early childhood home visitation services designed to improve health outcomes for pregnant women, postpartum mothers, and newborns and children, including maternal substance use disorders or depression and relationship-focused interventions for children with mental or nervous conditions or substance use disorders;

2. intensive, home-based services addressing specific mental or nervous conditions in a child while remediating problematic parenting practices and addressing other family and educational challenges that affect the child's and family's ability to function;
3. intensive, family- and community-based treatment programs that focus on environmental systems impacting chronic and violent juvenile offenders;
4. evidence-based family-focused therapy specializing in the treatment of juvenile substance use disorders and delinquency;
5. short-term family therapy intervention and juvenile diversion programs targeting at-risk children to address adolescent behavior problems, conduct disorders, substance use disorders, and delinquency;
6. other home-based therapeutic interventions for children;
7. chemical maintenance treatment (i.e., when a person is admitted for the planned use of a prescribed substance under medical supervision);
8. nonhospital inpatient, medically monitored, or ambulatory detoxification;
9. inpatient services at psychiatric residential treatment facilities;
10. extended day treatment programs for emotionally disturbed, mentally ill, behaviorally disordered, or multiply handicapped children and youth;
11. rehabilitation services provided in a licensed group home, community setting, or residential treatment facility;
12. observation beds in acute hospital settings;
13. emergency mobile psychiatric services;

14. case management by a licensed health care provider, including care coordination, communication, and treatment planning with other providers necessary to ensure adequate and appropriate treatment for an insured diagnosed with a mental or nervous condition;
15. psychological and neuropsychological testing by an appropriately licensed health care provider;
16. trauma screening by a licensed behavioral health professional;
17. depression screening, including maternal depression screening, by a licensed behavioral health professional; and
18. substance use screening by a licensed behavior health professional.

Acute Treatment and Clinical Stabilization Services without Prior Authorization

The bill also requires insurers to cover certain acute treatment and clinical stabilization services. "Acute treatment" is 24-hour medically supervised treatment for a substance use disorder provided in a medically managed or medically monitored inpatient facility. "Clinical stabilization" is 24-hour clinically managed postdetoxification treatment, including relapse prevention, family outreach, aftercare planning, and addiction education and counseling.

Under the bill, insurers must cover general inpatient hospitalization, including at state-operated facilities, and medically necessary services for up to 14 days without preauthorization for acute treatment and clinical stabilization services.

The bill requires the treating facility to, within 48 hours after the insured's admission, notify the insured's insurer of his or her admission and provide an initial treatment plan. The insurer may begin utilization review procedures seven days after the insured is admitted or begins treatment. (Utilization review is a health carrier's review of a covered person's benefits with respect to a certain medical

service).

COVERAGE FOR SERVICES PROVIDED BY AN APRN

The bill requires insurers to cover services for mental or nervous conditions provided by an APRN.

By law, insurers must already cover services provided by a licensed physician, psychologist, clinical social worker, marital and family therapist, or professional counselor. Existing law also covers services from certain certified marital and family therapists and independent social workers, as well as with licensed or certified alcohol and drug counselors.

BACKGROUND

Mental or Nervous Conditions

By law, “mental or nervous conditions” are mental disorders defined in the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM). This does not include (1) intellectual disabilities, (2) specific learning disorders, (3) motor disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) other conditions that may be a focus of clinical attention but are not defined as mental disorders in the DSM (CGS §§ 38a-488a & 38a-514).

Related Federal Law

Under the federal Patient Protection and Affordable Care Act (P.L. 111-148), a state may require health plans sold through the state’s health insurance exchange to offer benefits beyond those included in the required “essential health benefits,” provided the state defrays the cost of those additional benefits. The requirement applies to benefit mandates a state enacts after December 31, 2011. Thus, the state must pay the insurance carrier or enrollee to defray the cost of any new benefits mandated after that date.

Related Bills

sHB 6847, favorably reported by the Insurance and Real Estate

Committee, expands coverage for autism spectrum disorder (ASD). ASD is a mental and nervous condition covered under the provisions of this bill.

SB 16, favorably reported by the Insurance and Real Estate Committee, prohibits insurers from limiting the number of visits to assess an insured for a mental or nervous condition diagnosis, and requires insurers to cover certain consultations.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 19 Nay 0 (03/19/2015)