



Senate

General Assembly

February Session, 2016

File No. 427

Senate Bill No. 99

Senate, April 4, 2016

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 BENEFITS PAYABLE FOR ASSESSMENTS TO DETERMINE A DIAGNOSIS OF A CONDITION AND RELATED CONSULTATIONS.

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

1 Section 1. Section 38a-488a of the 2016 supplement to the general
2 statutes, as amended by section 44 of public act 15-5 of the June special
3 session, is repealed and the following is substituted in lieu thereof
4 (*Effective January 1, 2017*):

5 (a) For the purposes of this section: (1) "Mental or nervous
6 conditions" means mental disorders, as defined in the most recent
7 edition of the American Psychiatric Association's "Diagnostic and
8 Statistical Manual of Mental Disorders". "Mental or nervous
9 conditions" does not include (A) intellectual disabilities, (B) specific
10 learning disorders, (C) motor disorders, (D) communication disorders,
11 (E) caffeine-related disorders, (F) relational problems, and (G) other
12 conditions that may be a focus of clinical attention, that are not
13 otherwise defined as mental disorders in the most recent edition of the

14 American Psychiatric Association's "Diagnostic and Statistical Manual
15 of Mental Disorders"; (2) "benefits payable" means the usual,
16 customary and reasonable charges for treatment deemed necessary
17 under generally accepted medical standards, except that in the case of
18 a managed care plan, as defined in section 38a-478, "benefits payable"
19 means the payments agreed upon in the contract between a managed
20 care organization, as defined in section 38a-478, and a provider, as
21 defined in section 38a-478; (3) "acute treatment services" means
22 twenty-four-hour medically supervised treatment for a substance use
23 disorder, that is provided in a medically managed or medically
24 monitored inpatient facility; and (4) "clinical stabilization services"
25 means twenty-four-hour clinically managed postdetoxification
26 treatment, including, but not limited to, relapse prevention, family
27 outreach, aftercare planning and addiction education and counseling.

28 (b) Each individual health insurance policy providing coverage of
29 the type specified in subdivisions (1), (2), (4), (11) and (12) of section
30 38a-469 delivered, issued for delivery, renewed, amended or continued
31 in this state shall provide benefits for the diagnosis and treatment of
32 mental or nervous conditions. Benefits payable include, but need not
33 be limited to:

34 (1) General inpatient hospitalization, including in state-operated
35 facilities;

36 (2) Medically necessary acute treatment services and medically
37 necessary clinical stabilization services;

38 (3) General hospital outpatient services, including at state-operated
39 facilities;

40 (4) Psychiatric inpatient hospitalization, including in state-operated
41 facilities;

42 (5) Psychiatric outpatient hospital services, including at state-
43 operated facilities;

44 (6) Intensive outpatient services, including at state-operated

45 facilities;

46 (7) Partial hospitalization, including at state-operated facilities;

47 (8) Evidence-based maternal, infant and early childhood home
48 visitation services, as described in Section 2951 of the Patient
49 Protection and Affordable Care Act, P.L. 111-148, as amended from
50 time to time, that are designed to improve health outcomes for
51 pregnant women, postpartum mothers and newborns and children,
52 including, but not limited to, for maternal substance use disorders or
53 depression and relationship-focused interventions for children with
54 mental or nervous conditions or substance use disorders;

55 (9) Intensive, home-based services designed to address specific
56 mental or nervous conditions in a child;

57 (10) Evidence-based family-focused therapy that specializes in the
58 treatment of juvenile substance use disorders;

59 (11) Short-term family therapy intervention;

60 (12) Nonhospital inpatient detoxification;

61 (13) Medically monitored detoxification;

62 (14) Ambulatory detoxification;

63 (15) Inpatient services at psychiatric residential treatment facilities;

64 (16) Rehabilitation services provided in residential treatment
65 facilities, general hospitals, psychiatric hospitals or psychiatric
66 facilities;

67 (17) Observation beds in acute hospital settings;

68 (18) Psychological and neuropsychological testing conducted by an
69 appropriately licensed health care provider;

70 (19) Trauma screening conducted by a licensed behavioral health
71 professional;

72 (20) Depression screening, including maternal depression screening,
73 conducted by a licensed behavioral health professional;

74 (21) Substance use screening conducted by a licensed behavioral
75 health professional;

76 (22) Intensive, family-based and community-based treatment
77 programs that focus on addressing environmental systems that impact
78 chronic and violent juvenile offenders;

79 (23) Other home-based therapeutic interventions for children;

80 (24) Chemical maintenance treatment, as defined in section 19a-495-
81 570 of the regulations of Connecticut state agencies; and

82 (25) Extended day treatment programs, as described in section 17a-
83 22.

84 (c) No such policy shall establish any terms, conditions or benefits
85 that (1) place a greater financial burden on an insured for access to
86 diagnosis or treatment of mental or nervous conditions than for
87 diagnosis or treatment of medical, surgical or other physical health
88 conditions, [or] (2) prohibit an insured from obtaining or a health care
89 provider from being reimbursed for multiple screening services as part
90 of a single-day visit to a health care provider or a multicare institution,
91 as defined in section 19a-490, or (3) limit the number of visits to a
92 health care provider or a multicare institution to assess an insured for a
93 diagnosis of a condition.

94 (d) In the case of benefits payable for the services of a licensed
95 physician, such benefits shall be payable for the same services when
96 such services are lawfully rendered by a psychologist licensed under
97 the provisions of chapter 383 or by such a licensed psychologist in a
98 licensed hospital or clinic.

99 (e) In the case of benefits payable for the services of a licensed
100 physician or psychologist, such benefits shall be payable for the same
101 services when such services are rendered by:

102 (1) A clinical social worker who is licensed under the provisions of
103 chapter 383b and who has passed the clinical examination of the
104 American Association of State Social Work Boards and has completed
105 at least two thousand hours of post-master's social work experience in
106 a nonprofit agency qualifying as a tax-exempt organization under
107 Section 501(c) of the Internal Revenue Code of 1986 or any subsequent
108 corresponding internal revenue code of the United States, as from time
109 to time amended, in a municipal, state or federal agency or in an
110 institution licensed by the Department of Public Health under section
111 19a-490;

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

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

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

124 (5) A licensed alcohol and drug counselor, as defined in section 20-
125 74s, or a certified alcohol and drug counselor, as defined in section 20-
126 74s;

127 (6) A licensed professional counselor; or

128 (7) An advanced practice registered nurse licensed under the
129 provisions of chapter 378.

130 (f) (1) In the case of benefits payable for the services of a licensed
131 physician, such benefits shall be payable for (A) services rendered in a
132 child guidance clinic or residential treatment facility by a person with a

133 master's degree in social work or by a person with a master's degree in
134 marriage and family therapy under the supervision of a psychiatrist,
135 physician, licensed marital and family therapist, or licensed clinical
136 social worker who is eligible for reimbursement under subdivisions (1)
137 to (4), inclusive, of subsection (e) of this section; (B) services rendered
138 in a residential treatment facility by a licensed or certified alcohol and
139 drug counselor who is eligible for reimbursement under subdivision
140 (5) of subsection (e) of this section; or (C) services rendered in a
141 residential treatment facility by a licensed professional counselor who
142 is eligible for reimbursement under subdivision (6) of subsection (e) of
143 this section.

144 (2) In the case of benefits payable for the services of a licensed
145 psychologist under subsection (e) of this section, such benefits shall be
146 payable for (A) services rendered in a child guidance clinic or
147 residential treatment facility by a person with a master's degree in
148 social work or by a person with a master's degree in marriage and
149 family therapy under the supervision of such licensed psychologist,
150 licensed marital and family therapist, or licensed clinical social worker
151 who is eligible for reimbursement under subdivisions (1) to (4),
152 inclusive, of subsection (e) of this section; (B) services rendered in a
153 residential treatment facility by a licensed or certified alcohol and drug
154 counselor who is eligible for reimbursement under subdivision (5) of
155 subsection (e) of this section; or (C) services rendered in a residential
156 treatment facility by a licensed professional counselor who is eligible
157 for reimbursement under subdivision (6) of subsection (e) of this
158 section.

159 (g) In the case of benefits payable for the service of a licensed
160 physician practicing as a psychiatrist or a licensed psychologist, under
161 subsection (e) of this section, such benefits shall be payable for
162 outpatient services rendered (1) in a nonprofit community mental
163 health center, as defined by the Department of Mental Health and
164 Addiction Services, in a nonprofit licensed adult psychiatric clinic
165 operated by an accredited hospital or in a residential treatment facility;
166 (2) under the supervision of a licensed physician practicing as a

167 psychiatrist, a licensed psychologist, a licensed marital and family
168 therapist, a licensed clinical social worker, a licensed or certified
169 alcohol and drug counselor or a licensed professional counselor who is
170 eligible for reimbursement under subdivisions (1) to (6), inclusive, of
171 subsection (e) of this section; and (3) within the scope of the license
172 issued to the center or clinic by the Department of Public Health or to
173 the residential treatment facility by the Department of Children and
174 Families.

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

180 (i) In the case of any person admitted to a state institution or facility
181 administered by the Department of Mental Health and Addiction
182 Services, Department of Public Health, Department of Children and
183 Families or the Department of Developmental Services, the state shall
184 have a lien upon the proceeds of any coverage available to such person
185 or a legally liable relative of such person under the terms of this
186 section, to the extent of the per capita cost of such person's care. Except
187 in the case of emergency services, the provisions of this subsection
188 shall not apply to coverage provided under a managed care plan, as
189 defined in section 38a-478.

190 (j) In addition to the benefits payable under subsections (b) to (g),
191 inclusive, of this section, each such policy shall provide benefits for the
192 services of a provider specified in subsection (d) or (e) of this section
193 for any consultation with such provider that includes the insured or a
194 family member of the insured (1) during an assessment for a diagnosis
195 of a condition, and (2) after a diagnosis of a mental or nervous
196 condition has been made.

197 Sec. 2. Section 38a-514 of the 2016 supplement to the general
198 statutes, as amended by section 46 of public act 15-5 of the June special
199 session, is repealed and the following is substituted in lieu thereof

200 (Effective January 1, 2017):

201 (a) For the purposes of this section: (1) "Mental or nervous
202 conditions" means mental disorders, as defined in the most recent
203 edition of the American Psychiatric Association's "Diagnostic and
204 Statistical Manual of Mental Disorders". "Mental or nervous
205 conditions" does not include (A) intellectual disabilities, (B) specific
206 learning disorders, (C) motor disorders, (D) communication disorders,
207 (E) caffeine-related disorders, (F) relational problems, and (G) other
208 conditions that may be a focus of clinical attention, that are not
209 otherwise defined as mental disorders in the most recent edition of the
210 American Psychiatric Association's "Diagnostic and Statistical Manual
211 of Mental Disorders"; (2) "benefits payable" means the usual,
212 customary and reasonable charges for treatment deemed necessary
213 under generally accepted medical standards, except that in the case of
214 a managed care plan, as defined in section 38a-478, "benefits payable"
215 means the payments agreed upon in the contract between a managed
216 care organization, as defined in section 38a-478, and a provider, as
217 defined in section 38a-478; (3) "acute treatment services" means
218 twenty-four-hour medically supervised treatment for a substance use
219 disorder, that is provided in a medically managed or medically
220 monitored inpatient facility; and (4) "clinical stabilization services"
221 means twenty-four-hour clinically managed postdetoxification
222 treatment, including, but not limited to, relapse prevention, family
223 outreach, aftercare planning and addiction education and counseling.

224 (b) Except as provided in subsection (j) of this section, each group
225 health insurance policy providing coverage of the type specified in
226 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered,
227 issued for delivery, renewed, amended or continued in this state shall
228 provide benefits for the diagnosis and treatment of mental or nervous
229 conditions. Benefits payable include, but need not be limited to:

230 (1) General inpatient hospitalization, including in state-operated
231 facilities;

232 (2) Medically necessary acute treatment services and medically

- 233 necessary clinical stabilization services;
- 234 (3) General hospital outpatient services, including at state-operated
235 facilities;
- 236 (4) Psychiatric inpatient hospitalization, including in state-operated
237 facilities;
- 238 (5) Psychiatric outpatient hospital services, including at state-
239 operated facilities;
- 240 (6) Intensive outpatient services, including at state-operated
241 facilities;
- 242 (7) Partial hospitalization, including at state-operated facilities;
- 243 (8) Evidence-based maternal, infant and early childhood home
244 visitation services, as described in Section 2951 of the Patient
245 Protection and Affordable Care Act, P.L. 111-148, as amended from
246 time to time, that are designed to improve health outcomes for
247 pregnant women, postpartum mothers and newborns and children,
248 including, but not limited to, for maternal substance use disorders or
249 depression and relationship-focused interventions for children with
250 mental or nervous conditions or substance use disorders;
- 251 (9) Intensive, home-based services designed to address specific
252 mental or nervous conditions in a child;
- 253 (10) Evidence-based family-focused therapy that specializes in the
254 treatment of juvenile substance use disorders;
- 255 (11) Short-term family therapy intervention;
- 256 (12) Nonhospital inpatient detoxification;
- 257 (13) Medically monitored detoxification;
- 258 (14) Ambulatory detoxification;
- 259 (15) Inpatient services at psychiatric residential treatment facilities;
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260 (16) Rehabilitation services provided in residential treatment
261 facilities, general hospitals, psychiatric hospitals or psychiatric
262 facilities;

263 (17) Observation beds in acute hospital settings;

264 (18) Psychological and neuropsychological testing conducted by an
265 appropriately licensed health care provider;

266 (19) Trauma screening conducted by a licensed behavioral health
267 professional;

268 (20) Depression screening, including maternal depression screening,
269 conducted by a licensed behavioral health professional;

270 (21) Substance use screening conducted by a licensed behavioral
271 health professional;

272 (22) Intensive, family-based and community-based treatment
273 programs that focus on addressing environmental systems that impact
274 chronic and violent juvenile offenders;

275 (23) Other home-based therapeutic interventions for children;

276 (24) Chemical maintenance treatment, as defined in section 19a-495-
277 570 of the regulations of Connecticut state agencies; and

278 (25) Extended day treatment programs, as described in section 17a-
279 22.

280 (c) No such group policy shall establish any terms, conditions or
281 benefits that (1) place a greater financial burden on an insured for
282 access to diagnosis or treatment of mental or nervous conditions than
283 for diagnosis or treatment of medical, surgical or other physical health
284 conditions, [or] (2) prohibit an insured from obtaining or a health care
285 provider from being reimbursed for multiple screening services as part
286 of a single-day visit to a health care provider or a multicare institution,
287 as defined in section 19a-490, or (3) limit the number of visits to a
288 health care provider or a multicare institution to assess an insured for a

289 diagnosis of a condition.

290 (d) In the case of benefits payable for the services of a licensed
291 physician, such benefits shall be payable for the same services when
292 such services are lawfully rendered by a psychologist licensed under
293 the provisions of chapter 383 or by such a licensed psychologist in a
294 licensed hospital or clinic.

295 (e) In the case of benefits payable for the services of a licensed
296 physician or psychologist, such benefits shall be payable for the same
297 services when such services are rendered by:

298 (1) A clinical social worker who is licensed under the provisions of
299 chapter 383b and who has passed the clinical examination of the
300 American Association of State Social Work Boards and has completed
301 at least two thousand hours of post-master's social work experience in
302 a nonprofit agency qualifying as a tax-exempt organization under
303 Section 501(c) of the Internal Revenue Code of 1986 or any subsequent
304 corresponding internal revenue code of the United States, as from time
305 to time amended, in a municipal, state or federal agency or in an
306 institution licensed by the Department of Public Health under section
307 19a-490;

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

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

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

320 (5) A licensed alcohol and drug counselor, as defined in section 20-
321 74s, or a certified alcohol and drug counselor, as defined in section 20-
322 74s;

323 (6) A licensed professional counselor; or

324 (7) An advanced practice registered nurse licensed under the
325 provisions of chapter 378.

326 (f) (1) In the case of benefits payable for the services of a licensed
327 physician, such benefits shall be payable for (A) services rendered in a
328 child guidance clinic or residential treatment facility by a person with a
329 master's degree in social work or by a person with a master's degree in
330 marriage and family therapy under the supervision of a psychiatrist,
331 physician, licensed marital and family therapist or licensed clinical
332 social worker who is eligible for reimbursement under subdivisions (1)
333 to (4), inclusive, of subsection (e) of this section; (B) services rendered
334 in a residential treatment facility by a licensed or certified alcohol and
335 drug counselor who is eligible for reimbursement under subdivision
336 (5) of subsection (e) of this section; or (C) services rendered in a
337 residential treatment facility by a licensed professional counselor who
338 is eligible for reimbursement under subdivision (6) of subsection (e) of
339 this section.

340 (2) In the case of benefits payable for the services of a licensed
341 psychologist under subsection (e) of this section, such benefits shall be
342 payable for (A) services rendered in a child guidance clinic or
343 residential treatment facility by a person with a master's degree in
344 social work or by a person with a master's degree in marriage and
345 family therapy under the supervision of such licensed psychologist,
346 licensed marital and family therapist or licensed clinical social worker
347 who is eligible for reimbursement under subdivisions (1) to (4),
348 inclusive, of subsection (e) of this section; (B) services rendered in a
349 residential treatment facility by a licensed or certified alcohol and drug
350 counselor who is eligible for reimbursement under subdivision (5) of
351 subsection (e) of this section; or (C) services rendered in a residential
352 treatment facility by a licensed professional counselor who is eligible

353 for reimbursement under subdivision (6) of subsection (e) of this
354 section.

355 (g) In the case of benefits payable for the service of a licensed
356 physician practicing as a psychiatrist or a licensed psychologist, under
357 subsection (e) of this section, such benefits shall be payable for
358 outpatient services rendered (1) in a nonprofit community mental
359 health center, as defined by the Department of Mental Health and
360 Addiction Services, in a nonprofit licensed adult psychiatric clinic
361 operated by an accredited hospital or in a residential treatment facility;
362 (2) under the supervision of a licensed physician practicing as a
363 psychiatrist, a licensed psychologist, a licensed marital and family
364 therapist, a licensed clinical social worker, a licensed or certified
365 alcohol and drug counselor, or a licensed professional counselor who
366 is eligible for reimbursement under subdivisions (1) to (6), inclusive, of
367 subsection (e) of this section; and (3) within the scope of the license
368 issued to the center or clinic by the Department of Public Health or to
369 the residential treatment facility by the Department of Children and
370 Families.

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

376 (i) In the case of any person admitted to a state institution or facility
377 administered by the Department of Mental Health and Addiction
378 Services, Department of Public Health, Department of Children and
379 Families or the Department of Developmental Services, the state shall
380 have a lien upon the proceeds of any coverage available to such person
381 or a legally liable relative of such person under the terms of this
382 section, to the extent of the per capita cost of such person's care. Except
383 in the case of emergency services the provisions of this subsection shall
384 not apply to coverage provided under a managed care plan, as defined
385 in section 38a-478.

386 (j) A group health insurance policy may exclude the benefits
387 required by this section if such benefits are included in a separate
388 policy issued to the same group by an insurance company, health care
389 center, hospital service corporation, medical service corporation or
390 fraternal benefit society. Such separate policy, which shall include the
391 benefits required by this section and the benefits required by section
392 38a-533, shall not be required to include any other benefits mandated
393 by this title.

394 (k) In the case of benefits based upon confinement in a residential
395 treatment facility, such benefits shall be payable in situations in which
396 the insured has a serious mental or nervous condition that
397 substantially impairs the insured's thoughts, perception of reality,
398 emotional process or judgment or grossly impairs the behavior of the
399 insured, and, upon an assessment of the insured by a physician,
400 psychiatrist, psychologist or clinical social worker, cannot
401 appropriately, safely or effectively be treated in an acute care, partial
402 hospitalization, intensive outpatient or outpatient setting.

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

409 (m) In addition to the benefits payable under subsections (b) to (g),
410 inclusive, and subsections (k) and (l) of this section, each such policy
411 shall provide benefits for the services of a provider specified in
412 subsection (d) or (e) of this section for any consultation with such
413 provider that includes the insured or a family member of the insured
414 (1) during an assessment for a diagnosis of a condition, and (2) after a
415 diagnosis of a mental or nervous condition has been made.

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

Section 1	<i>January 1, 2017</i>	38a-488a
Sec. 2	<i>January 1, 2017</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 17 \$	FY 18 \$
State Comptroller – Fringe Benefits (State Employee and Retiree Health Accounts)	GF&TF - Cost	\$25,000	\$50,000
The State	Cost	\$14,000	\$28,000

Note: GF&TF=General Fund & Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 17 \$	FY 18 \$
Various Municipalities	STATE MANDATE - Cost	\$15,200	\$30,500

Explanation

The bill will result in a cost to the state employee and retiree health plan¹, municipalities, and the state, related to prohibiting a limit on the number of diagnostic visits. The total estimated cost to the state in FY 17 is approximately \$39,000 and \$78,000 in FY 18. This cost is attributable to (1) the estimated cost to the state plan in FY 17 and FY 18 of approximately \$25,000 and \$50,000 respectively and (2) the cost to the state pursuant to the federal Affordable Care Act (ACA) (see below) in FY 17 and FY 18 of approximately \$14,000 and \$28,000 respectively. The cost to fully insured municipalities in FY 17 and FY 18 is approximately \$15,200 and \$30,500 respectively.²

If adopted by the state plan, the actual cost to the plan will depend

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.

² The estimated cost is based on the per member per month (PMPM) impact of \$.02. The cost estimate for the state employee plan is based on the plan membership as of February 2016; municipal impact is based on Dept. of Labor employment information as of January 2016; state impact based on Exchange enrollment as of February 2016.

on the utilization of services by the plan's population.

Municipal Impact

As previously stated, the bill will increase costs to certain fully insured, municipal plans that limit the number of diagnostic visits. The coverage requirements may result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2017. In addition, many municipal health plans are recognized as "grandfathered" health plans under the ACA.³ 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.

The State and the federal ACA

Lastly, the ACA requires that, the state's health exchange's qualified health plans (QHPs)⁴, include a federally defined essential health benefits package (EHB). The federal government is allowing states to choose a benchmark plan⁵ 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. Absent additional federal guidance, state mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB unless they are already part of the benchmark plan.⁶ However, neither the agency

³ Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010.

⁴ 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.

⁵ The state's benchmark plan is the Connecticare HMO plan with supplemental coverage for pediatric dental and vision care as required by the ACA.

⁶ Source: Dept. of Health and Human Services. *Frequently Asked Questions on Essential Health Benefits Bulletin* (February 21, 2012).

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 covered lives in the state, municipal and exchange health plans, and (3) the utilization of services.

*Sources: Department of Labor
Office of the State Comptroller*

OLR Bill Analysis**SB 99*****AN ACT CONCERNING BENEFITS PAYABLE FOR ASSESSMENTS TO DETERMINE A DIAGNOSIS OF A CONDITION AND RELATED CONSULTATIONS.*****SUMMARY:**

This bill expands coverage for mental or nervous condition assessments and consultations under certain health insurance policies. It prohibits insurers from limiting the number of visits to assess an insured for such a condition and requires insurers to cover consultations between the insured, or his or her family member, and the health care provider (1) during an assessment for a diagnosis of a mental or nervous condition and (2) after diagnosis of such condition. Consultations must be provided by (1) licensed physicians, psychologists, clinical social workers, marital and family therapists, or professional counselors, or (2) certain certified marital and family therapists, independent social workers, and licensed or certified alcohol and drug counselors. (The bill does not define the terms “consultation” or “family member.”)

The bill applies to individual and group health insurance policies delivered, issued, 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 under an HMO plan. Due to the federal Employee Retirement Income Security Act, state insurance mandates do not apply to self-insured benefit plans.

The bill also makes technical and conforming changes.

EFFECTIVE DATE: January 1, 2017

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-5). This does not include (1) intellectual disabilities, (2) specific learning disorders, (3) motor disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, or (7) other conditions that may be a focus of clinical attention but are not defined as mental disorders in the DSM (CGS § 38a-488a).

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.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 11 Nay 8 (03/16/2016)