



General Assembly

February Session, 2018

Raised Bill No. 384

LCO No. 1875



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING MENTAL HEALTH PARITY, DATA REPORTED BY MANAGED CARE ORGANIZATIONS AND THE ALL-PAYER CLAIMS DATABASE.

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

1 Section 1. (NEW) (*Effective January 1, 2019*) For the purposes of this
2 section and sections 2 to 5, inclusive, of this act:

3 (1) "Commissioner" means the Insurance Commissioner.

4 (2) "Covered benefits" means any health care services to which an
5 enrollee or insured is entitled under the terms of any individual or
6 group health insurance policy.

7 (3) "Department" means the Insurance Department.

8 (4) "Generally accepted standards of medical practice" has the same
9 meaning as provided in section 38a-482a of the general statutes.

10 (5) "Group health insurance policy" means any group health
11 insurance policy providing coverage of the type specified in

12 subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 of the
13 general statutes.

14 (6) "Health care provider" or "provider" means a person licensed to
15 provide health care services under chapters 370 to 373, inclusive, 375 to
16 383c, inclusive, 384a to 384c, inclusive, and 400j of the general statutes.

17 (7) "Health care services" or "services" means services for the
18 diagnosis, prevention, treatment, cure or relief of a mental or nervous
19 condition, physical health condition or substance use disorder.

20 (8) "Health carrier" or "carrier" means an insurer, fraternal benefit
21 society, health care center, hospital service corporation, managed care
22 organization, medical service corporation or other entity that delivers,
23 issues for delivery, renews, amends or continues in this state any
24 individual or group health insurance policy.

25 (9) "Individual health insurance policy" means any individual health
26 insurance policy providing coverage of the type specified in
27 subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 of the
28 general statutes.

29 (10) "Medically necessary" or "medical necessity" means health care
30 services that a provider, actively practicing in this state in the relevant
31 practice area and exercising prudent clinical judgment, would provide
32 to a patient for the purpose of preventing, evaluating, diagnosing or
33 treating an illness, injury, disease or its symptoms, and that are (A) in
34 accordance with generally accepted standards of medical practice, (B)
35 clinically appropriate, in terms of type, frequency, extent, site and
36 duration and considered effective for the patient's illness, injury or
37 disease, and (C) not primarily for the convenience of the patient or
38 provider and not more costly than an alternative service or sequence of
39 services at least as likely to produce equivalent therapeutic or
40 diagnostic results as to the diagnosis or treatment of that patient's
41 illness, injury or disease.

42 (11) "Mental health benefits" means covered benefits for any health

43 care services rendered to prevent, evaluate, diagnose or treat one or
44 more mental or nervous conditions.

45 (12) "Mental Health Parity and Addiction Equity Act" means the
46 Paul Wellstone and Pete Domenici Mental Health Parity and
47 Addiction Equity Act of 2008, P.L. 110-343, as amended from time to
48 time, and regulations adopted thereunder.

49 (13) "Mental or nervous condition" has the same meaning as
50 provided in section 38a-488a of the general statutes, as amended by
51 this act.

52 (14) "Nonquantitative treatment limitation" means any evidentiary
53 standard, process, strategy or other nonnumerical factor that has the
54 effect of denying or limiting a covered benefit.

55 (15) "Physical health benefits" means covered benefits for any health
56 care services rendered to prevent, evaluate, diagnose or treat one or
57 more physical health conditions.

58 (16) "Physical health condition" means any illness or dysfunction of,
59 or injury to, the human body. "Physical health condition" does not
60 include any (A) mental or nervous condition, or (B) substance use
61 disorder.

62 (17) "Substance abuse benefits" means covered benefits for any
63 health care services rendered to prevent, evaluate, diagnose or treat
64 one or more substance use disorders.

65 (18) "Substance use disorder" means any moderate or severe alcohol
66 or substance use disorder, as defined in the most recent edition of the
67 American Psychiatric Association's "Diagnostic and Statistical Manual
68 of Mental Disorders."

69 Sec. 2. (NEW) (*Effective January 1, 2019*) Each health carrier shall
70 comply with the Mental Health Parity and Addiction Equity Act in
71 addition to the requirements of state laws and regulations. If there is a
72 conflict, the Mental Health Parity and Addiction Equity Act shall

73 govern.

74 Sec. 3. (NEW) (*Effective January 1, 2019*) (a) On or before March first
75 of each year, each health carrier shall submit to the commissioner a
76 report covering the preceding calendar year. The report shall be on a
77 form prescribed by the commissioner and shall include:

78 (1) (A) With respect to claims for mental health benefits the carrier
79 received, and for each category of services set forth in subparagraph
80 (D) of this subdivision, (i) the ratio of the total number of claims for
81 which the carrier required prior authorization to the total number of
82 claims the carrier received, (ii) the ratio of the total number of claims
83 the carrier denied to the total number of claims the carrier received,
84 (iii) the reason the carrier denied any claim, and (iv) the amount of the
85 reimbursement that the carrier paid to the provider who provided
86 such benefits;

87 (B) With respect to claims for physical health benefits the carrier
88 received, and for each category of services set forth in subparagraph
89 (D) of this subdivision, (i) the ratio of the total number of claims for
90 which the carrier required prior authorization to the total number of
91 claims the carrier received, (ii) the ratio of the total number of claims
92 the carrier denied to the total number of claims the carrier received,
93 (iii) the reason the carrier denied any claim, and (iv) the amount of the
94 reimbursement that the carrier paid to the provider who provided
95 such benefits;

96 (C) With respect to claims for substance abuse benefits the carrier
97 received, and for each category of services set forth in subparagraph
98 (D) of this subdivision, (i) the ratio of the total number of claims for
99 which the carrier required prior authorization to the total number of
100 claims the carrier received, (ii) the ratio of the total number of claims
101 the carrier denied to the total number of claims the carrier received,
102 (iii) the reason the carrier denied any claim, and (iv) the amount of the
103 reimbursement that the carrier paid to the provider who provided
104 such benefits; and

105 (D) Each carrier shall disclose information under subparagraphs (A)
106 to (C), inclusive, of this subdivision for (i) in-network services
107 provided on an inpatient basis, (ii) in-network services provided on an
108 outpatient basis, (iii) out-of-network services provided on an inpatient
109 basis, (iv) out-of-network services provided on an outpatient basis, (v)
110 emergency medical services, and (vi) pharmaceutical services and
111 products;

112 (2) With respect to any criteria the carrier used to determine
113 whether a particular service was medically necessary and therefore
114 covered as a mental health benefit, physical health benefit or substance
115 abuse benefit, a statement (A) describing the criteria, (B) describing all
116 processes and methods used to develop the criteria, and (C) with
117 respect to any criteria developed by the carrier, a statement by the
118 carrier certifying that an independent provider, actively practicing in
119 this state and in the relevant specialty area, determined that the criteria
120 were, at the time the carrier adopted the criteria, consistent with
121 generally accepted standards of medical practice;

122 (3) With respect to each nonquantitative treatment limitation the
123 carrier used during the relevant calendar year, a statement (A)
124 describing the nonquantitative treatment limitation, (B) disclosing
125 whether the carrier used the nonquantitative treatment limitation with
126 respect to claims for mental health benefits, physical health benefits,
127 substance abuse benefits or any combination thereof, (C) describing all
128 processes and methods used to develop the nonquantitative treatment
129 limitation, (D) describing all factors the carrier considered and used in
130 determining whether it would apply the nonquantitative treatment
131 limitation to a particular covered benefit, (E) describing all factors the
132 carrier considered but did not use in determining whether it would
133 apply the nonquantitative treatment limitation to a particular covered
134 benefit, (F) by the carrier certifying that it did not apply the
135 nonquantitative treatment limitation more stringently to claims for
136 mental health benefits and substance abuse benefits than physical
137 health benefits, and (G) describing the processes and methods the
138 carrier used to ensure that it did not apply the nonquantitative

139 treatment limitation more stringently to claims for mental health
140 benefits or substance abuse benefits than claims for physical health
141 benefits;

142 (4) A statement from the carrier certifying, after review of its
143 internal standards, practices and procedures, that it is in compliance
144 with (A) sections 38a-488a and 38a-514 of the general statutes, as
145 amended by this act, as applicable, (B) the Mental Health Parity and
146 Addiction Equity Act, and (C) the Patient Protection and Affordable
147 Care Act, P.L. 111-148, as amended from time to time, and regulations
148 adopted thereunder; and

149 (5) Any other information as the commissioner may require.

150 (b) The commissioner may require that any carrier, in making a
151 report under subsection (a) of this section, disclose information
152 deemed by the carrier to be of a proprietary or competitive nature,
153 provided the commissioner shall maintain the information as
154 confidential and shall not disclose the information to any person
155 except to the extent necessary to carry out the purposes of sections 1 to
156 5, inclusive, of this act. For the purposes of sections 1 to 5, inclusive, of
157 this act, information is of a proprietary or competitive nature if
158 revealing the information would cause the carrier's competitors to
159 obtain valuable business information.

160 (c) The information required under subsection (a) of this section
161 shall be posted on the department's Internet web site, except that no
162 information that is of a proprietary or competitive nature within the
163 meaning of subsection (b) of this section shall be posted on the
164 department's Internet web site.

165 (d) The commissioner may accept any part of the filing required
166 under subsection (a) of this section in electronic form.

167 Sec. 4. (NEW) (*Effective January 1, 2019*) (a) Not later than June 1,
168 2019, and annually thereafter, the commissioner shall submit a report,
169 in accordance with section 11-4a of the general statutes, to the joint

170 standing committee of the General Assembly having cognizance of
171 matters relating to insurance. The report shall include the following
172 information and statements for the preceding calendar year:

173 (1) A statement describing all processes and methods the
174 department used to ensure that each health carrier complied with the
175 Mental Health Parity and Addiction Equity Act and the results of such
176 processes and methods;

177 (2) A statement describing all processes and methods the
178 department used to ensure that each carrier complied with sections
179 38a-488a and 38a-514 of the general statutes, as amended by this act,
180 and the results of such processes and methods;

181 (3) A statement describing any efforts the department made to
182 educate carriers concerning compliance with section 2 of this act and
183 any regulations adopted under section 5 of this act;

184 (4) A statement describing any efforts the department made to
185 educate the public concerning the requirement that carriers comply
186 with section 2 of this act and any regulations adopted under section 5
187 of this act; and

188 (5) A statement describing any actions the department has taken to
189 enforce section 2 of this act or any regulations adopted under section 5
190 of this act.

191 (b) The report required under subsection (a) of this section shall be
192 in plain language.

193 (c) The report required under subsection (a) of this section shall be
194 posted on the department's Internet web site.

195 (d) The joint standing committee of the General Assembly having
196 cognizance of matters relating to insurance may require the
197 commissioner to attend an informational hearing following its receipt
198 of a report submitted under subsection (a) of this section. The
199 commissioner shall attend and be available for questions from the

200 members of the committee at the hearing.

201 Sec. 5. (NEW) (*Effective January 1, 2019*) The commissioner shall
202 adopt regulations, in accordance with chapter 54 of the general
203 statutes, to implement the provisions of this section and sections 1 to 4,
204 inclusive, of this act.

205 Sec. 6. Section 38a-478c of the general statutes is repealed and the
206 following is substituted in lieu thereof (*Effective January 1, 2019*):

207 (a) On or before May first of each year, each managed care
208 organization shall submit to the commissioner:

209 (1) A report on its quality assurance plan that includes, but is not
210 limited to, information on complaints related to providers and quality
211 of care, on decisions related to patient requests for coverage and on
212 prior authorization statistics. Statistical information shall be submitted
213 in a manner permitting comparison across plans and shall include, but
214 not be limited to: (A) The ratio of the number of complaints received to
215 the number of enrollees; (B) a summary of the complaints received
216 related to providers and delivery of care or services and the action
217 taken on the complaint; (C) the ratio of the number of prior
218 authorizations denied to the number of prior authorizations requested;
219 (D) the number of utilization review determinations made by or on
220 behalf of a managed care organization not to certify an admission,
221 service, procedure or extension of stay, and the denials upheld and
222 reversed on appeal within the managed care organization's utilization
223 review procedure; (E) the percentage of those employers or groups
224 that renew their contracts within the previous twelve months; and (F)
225 notwithstanding the provisions of this subsection, on or before July
226 first of each year, all data required by the National Committee for
227 Quality Assurance for its Health Plan Employer Data and Information
228 Set. If an organization does not provide information for the National
229 Committee for Quality Assurance for its Health Plan Employer Data
230 and Information Set, then it shall provide such other equivalent data as
231 the commissioner may require by regulations adopted in accordance

232 with the provisions of chapter 54. The commissioner shall find that the
233 requirements of this subdivision have been met if the managed care
234 plan has received a one-year or higher level of accreditation by the
235 National Committee for Quality Assurance and has submitted the
236 Health Plan Employee Data Information Set data required by
237 subparagraph (F) of this subdivision;

238 (2) A model contract that contains the provisions currently in force
239 in contracts between the managed care organization and preferred
240 provider networks in this state, and the managed care organization
241 and participating providers in this state and, upon the commissioner's
242 request, a copy of any individual contracts between such parties,
243 provided the contract may withhold or redact proprietary fee schedule
244 information;

245 (3) A written statement of the types of financial arrangements or
246 contractual provisions that the managed care organization has with
247 hospitals, utilization review companies, physicians, preferred provider
248 networks and any other health care providers including, but not
249 limited to, compensation based on a fee-for-service arrangement, a
250 risk-sharing arrangement or a capitated risk arrangement;

251 (4) Such information as the commissioner deems necessary to
252 complete the consumer report card required pursuant to section 38a-
253 478l, as amended by this act. Such information may include, but need
254 not be limited to: (A) The organization's characteristics, including its
255 model, its profit or nonprofit status, its address and telephone number,
256 the length of time it has been licensed in this and any other state, its
257 number of enrollees and whether it has received any national or
258 regional accreditation; (B) a summary of the information required by
259 subdivision (3) of this subsection, including any change in a plan's
260 rates over the prior three years, its state medical loss ratio and its
261 federal medical loss ratio, as both terms are defined in section 38a-478l,
262 as amended by this act, how it compensates health care providers and
263 its premium level; (C) a description of services, the number of primary
264 care physicians and specialists, the number and nature of participating

265 preferred provider networks and the distribution and number of
266 hospitals, by county; (D) utilization review information, including the
267 name or source of any established medical protocols and the utilization
268 review standards; (E) medical management information, including the
269 provider-to-patient ratio by primary care provider and specialty care
270 provider, the percentage of primary and specialty care providers who
271 are board certified, and how the medical protocols incorporate input as
272 required in section 38a-478e; (F) the quality assurance information
273 required to be submitted under the provisions of subdivision (1) of
274 subsection (a) of this section; (G) the status of the organization's
275 compliance with the reporting requirements of this section; (H)
276 whether the organization markets to individuals and Medicare
277 recipients; (I) the number of hospital days per thousand enrollees; and
278 (J) the average length of hospital stays for specific procedures, as may
279 be requested by the commissioner;

280 (5) A summary of the procedures used by managed care
281 organizations to credential providers; [and]

282 (6) A report on claims denial data for lives covered in the state for
283 the prior calendar year, in a format prescribed by the commissioner,
284 that includes: (A) The total number of claims received; (B) the total
285 number of claims denied; (C) the total number of denials that were
286 appealed; (D) the total number of denials that were reversed upon
287 appeal; (E) (i) the reasons for the denials, including, but not limited to,
288 "not a covered benefit", "not medically necessary" and "not an eligible
289 enrollee", (ii) the total number of times each reason was used, and (iii)
290 the percentage of the total number of denials each reason was used;
291 and (F) other information the commissioner deems necessary; [.]

292 (7) A report, by county, on: (A) The estimated prevalence of
293 substance use disorders, as described in section 17a-458, among
294 covered children, young adults and adults; (B) the number and
295 percentage of covered children, young adults and adults, who received
296 covered treatment of a substance use disorder, by level of care
297 provided; (C) the median length of a covered treatment provided to

298 covered children, young adults and adults, for a substance use
299 disorder, by level of care provided; (D) the per member, per month
300 claim expenses for covered children, young adults and adults who
301 received covered treatment of substance use disorders; and (E) the
302 number of in-network health care providers who provide treatment of
303 substance use disorders, by level of care and the percentage of such
304 providers who are accepting new clients under such managed care
305 organization's plan or plans. For purposes of this subdivision,
306 "children" means individuals less than sixteen years of age, "young
307 adults" means individuals sixteen years of age or older but less than
308 twenty-six years of age and "adults" means individuals twenty-six
309 years of age or older;

310 (8) A state-wide report on the number, by licensure type, of health
311 care providers who provide treatment of substance use disorders, co-
312 occurring disorders and mental disorders, who, in the calendar year
313 immediately preceding for the initial report and since the last report
314 submitted to the commissioner for subsequent reports, (A) have
315 applied for in-network status and the percentage of those who were
316 accepted for such status, and (B) no longer participate in the network;

317 (9) A state-wide report on the number, by level of care provided, of
318 health care facilities that provide treatment of substance use disorders,
319 co-occurring disorders and mental disorders, that, in the calendar year
320 immediately preceding for the initial report and since the last report
321 submitted to the commissioner for subsequent reports, (A) have
322 applied for in-network status and the percentage of those that were
323 accepted for such status, and (B) no longer participate in the network;

324 (10) A report identifying and explaining factors that may be
325 negatively impacting covered individuals' access to treatment of
326 substance use disorders, including, but not limited to, screening
327 procedures, the supply, state wide, of certain categories of health care
328 providers, health care provider capacity limitations and provider
329 reimbursement rates; and

330 (11) Plans and ongoing or completed activities to address the factors
331 identified in subdivision (10) of this subsection.

332 (b) The information required pursuant to subdivisions (1) to (6),
333 inclusive, of subsection (a) of this section shall be consistent with the
334 data required by the National Committee for Quality Assurance
335 (NCQA) for its Health Plan Employer Data and Information Set
336 (HEDIS).

337 (c) The commissioner may accept electronic filing for any of the
338 requirements under this section.

339 (d) No managed care organization shall be liable for a claim arising
340 out of the submission of any information concerning complaints
341 concerning providers, provided the managed care organization
342 submitted the information in good faith.

343 (e) The information required under subdivision (6) of subsection (a)
344 of this section shall be posted on the Insurance Department's Internet
345 web site.

346 Sec. 7. Section 38a-478l of the general statutes is repealed and the
347 following is substituted in lieu thereof (*Effective January 1, 2019*):

348 (a) Not later than October fifteenth of each year, the Insurance
349 Commissioner, after consultation with the Commissioner of Public
350 Health, shall develop and distribute a consumer report card on all
351 managed care organizations. The commissioner shall develop the
352 consumer report card in a manner permitting consumer comparison
353 across organizations.

354 (b) (1) The consumer report card shall be known as the "Consumer
355 Report Card on Health Insurance Carriers in Connecticut" and shall
356 include (A) all health care centers licensed pursuant to chapter 698a,
357 (B) the fifteen largest licensed health insurers that use provider
358 networks and that are not included in subparagraph (A) of this
359 subdivision, (C) the state medical loss ratio of each such health care

360 center or licensed health insurer, (D) the federal medical loss ratio of
361 each such health care center or licensed health insurer, (E) the
362 information required under [subdivision] subdivisions (6) and (7) of
363 subsection (a) of section 38a-478c, as amended by this act, and (F) the
364 information [concerning mental health services, as specified in]
365 required under subsection (c) of this section for each such licensed
366 health insurer. The insurers selected pursuant to subparagraph (B) of
367 this subdivision shall be selected on the basis of Connecticut direct
368 written health premiums from such network plans.

369 (2) For the purposes of this section and sections 38a-477c, 38a-478c,
370 as amended by this act, and 38a-478g:

371 (A) "State medical loss ratio" means the ratio of incurred claims to
372 earned premiums for the prior calendar year for managed care plans
373 issued in the state. Claims shall be limited to medical expenses for
374 services and supplies provided to enrollees and shall not include
375 expenses for stop loss coverage, reinsurance, enrollee educational
376 programs or other cost containment programs or features;

377 (B) "Federal medical loss ratio" has the same meaning as provided
378 in, and shall be calculated in accordance with, the Patient Protection
379 and Affordable Care Act, P.L. 111-148, as amended from time to time,
380 and regulations adopted thereunder.

381 (c) [With respect to mental health services, the consumer report card
382 shall include information or measures with respect to the percentage of
383 enrollees receiving mental health services, utilization of mental health
384 and chemical dependence services, inpatient and outpatient
385 admissions, discharge rates and average lengths of stay.] (1) On or
386 before May first of each year, each health insurer that provides
387 coverage as set forth in section 38a-488a, as amended by this act, or
388 38a-514, as amended by this act, shall submit to the commissioner:

389 (A) Data for benefit requests, utilization review of benefit requests,
390 adverse determinations and final adverse determinations for the
391 treatment of acute and routine substance use disorders, co-occurring

392 disorders and mental disorders: (i) Grouped according to levels of
393 care, including, but not limited to, inpatient, outpatient, residential
394 care and partial hospitalization; (ii) grouped by category for substance
395 use disorders, co-occurring disorders and mental disorders; and (iii)
396 grouped by children, young adults and adults. For purposes of this
397 subparagraph, "children" means individuals less than sixteen years of
398 age, "young adults" means individuals sixteen years of age or older but
399 less than twenty-six years of age and "adults" means individuals
400 twenty-six years of age or older; and

401 (B) Data for external appeals for the treatment of substance use
402 disorders, co-occurring disorders and mental disorders, as set forth in
403 subparagraphs (A)(i) to (A)(iii), inclusive, of this subdivision.

404 (2) Such data shall be collected in a manner consistent with the
405 National Committee for Quality Assurance Health Plan Employer Data
406 and Information Set measures.

407 (d) The commissioner shall test market a draft of the consumer
408 report card prior to its publication and distribution. As a result of such
409 test marketing, the commissioner may make any necessary
410 modification to its form or substance. The Insurance Department shall
411 prominently display a link to the consumer report card on the
412 department's Internet web site.

413 (e) The commissioner shall analyze annually the data submitted
414 under subparagraphs (E) and (F) of subdivision (1) of subsection (b) of
415 this section for the accuracy of, trends in and statistically significant
416 differences in such data among the health care centers and licensed
417 health insurers included in the consumer report card. The
418 commissioner may investigate any such differences to determine
419 whether further action by the commissioner is warranted.

420 Sec. 8. Section 38a-488a of the 2018 supplement to the general
421 statutes is repealed and the following is substituted in lieu thereof
422 (*Effective January 1, 2019*):

423 (a) For the purposes of this section: (1) "Mental or nervous
424 conditions" means mental disorders, as defined in the most recent
425 edition of the American Psychiatric Association's "Diagnostic and
426 Statistical Manual of Mental Disorders". "Mental or nervous
427 conditions" does not include (A) intellectual disability, (B) specific
428 learning disorders, (C) motor disorders, (D) communication disorders,
429 (E) caffeine-related disorders, (F) relational problems, and (G) other
430 conditions that may be a focus of clinical attention, that are not
431 otherwise defined as mental disorders in the most recent edition of the
432 American Psychiatric Association's "Diagnostic and Statistical Manual
433 of Mental Disorders"; (2) "benefits payable" means the usual,
434 customary and reasonable charges for treatment deemed necessary
435 under generally accepted medical standards, except that in the case of
436 a managed care plan, as defined in section 38a-478, "benefits payable"
437 means the payments agreed upon in the contract between a managed
438 care organization, as defined in section 38a-478, and a provider, as
439 defined in section 38a-478; (3) "acute treatment services" means
440 twenty-four-hour medically supervised treatment for a substance use
441 disorder, that is provided in a medically managed or medically
442 monitored inpatient facility; and (4) "clinical stabilization services"
443 means twenty-four-hour clinically managed postdetoxification
444 treatment, including, but not limited to, relapse prevention, family
445 outreach, aftercare planning and addiction education and counseling.

446 (b) Each individual health insurance policy providing coverage of
447 the type specified in subdivisions (1), (2), (4), (11) and (12) of section
448 38a-469 delivered, issued for delivery, renewed, amended or continued
449 in this state shall provide benefits for the diagnosis and treatment of
450 mental or nervous conditions. Benefits payable include, but need not
451 be limited to:

452 (1) General inpatient hospitalization, including in state-operated
453 facilities;

454 (2) Medically necessary acute treatment services and medically
455 necessary clinical stabilization services;

456 (3) General hospital outpatient services, including at state-operated
457 facilities;

458 (4) Psychiatric inpatient hospitalization, including in state-operated
459 facilities;

460 (5) Psychiatric outpatient hospital services, including at state-
461 operated facilities;

462 (6) Intensive outpatient services, including at state-operated
463 facilities;

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

465 (8) Intensive, home-based services designed to address specific
466 mental or nervous conditions in a child;

467 (9) Evidence-based family-focused therapy that specializes in the
468 treatment of juvenile substance use disorders;

469 (10) Short-term family therapy intervention;

470 (11) Nonhospital inpatient detoxification;

471 (12) Medically monitored detoxification;

472 (13) Ambulatory detoxification;

473 (14) Inpatient services at psychiatric residential treatment facilities;

474 (15) Rehabilitation services provided in residential treatment
475 facilities, general hospitals, psychiatric hospitals or psychiatric
476 facilities;

477 (16) Observation beds in acute hospital settings;

478 (17) Psychological and neuropsychological testing conducted by an
479 appropriately licensed health care provider;

480 (18) Trauma screening conducted by a licensed behavioral health

481 professional;

482 (19) Depression screening, including maternal depression screening,
483 conducted by a licensed behavioral health professional;

484 (20) Substance use screening conducted by a licensed behavioral
485 health professional; and

486 (21) Screening for mental or nervous conditions during any annual
487 physical examination conducted by a licensed physician.

488 (c) No such policy shall establish any terms, conditions or benefits
489 that place a greater financial burden on an insured for access to
490 diagnosis or treatment of mental or nervous conditions than for
491 diagnosis or treatment of medical, surgical or other physical health
492 conditions, or prohibit an insured from obtaining or a health care
493 provider from being reimbursed for multiple screening services as part
494 of a single-day visit to a health care provider or a multicare institution,
495 as defined in section 19a-490.

496 (d) In the case of benefits payable for the services of a licensed
497 physician, such benefits shall be payable for the same services when
498 such services are lawfully rendered by a psychologist licensed under
499 the provisions of chapter 383 or by such a licensed psychologist in a
500 licensed hospital or clinic.

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

504 (1) A clinical social worker who is licensed under the provisions of
505 chapter 383b and who has passed the clinical examination of the
506 American Association of State Social Work Boards and has completed
507 at least two thousand hours of post-master's social work experience in
508 a nonprofit agency qualifying as a tax-exempt organization under
509 Section 501(c) of the Internal Revenue Code of 1986 or any subsequent
510 corresponding internal revenue code of the United States, as from time

511 to time amended, in a municipal, state or federal agency or in an
512 institution licensed by the Department of Public Health under section
513 19a-490;

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

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

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

526 (5) A licensed alcohol and drug counselor, as defined in section 20-
527 74s, or a certified alcohol and drug counselor, as defined in section 20-
528 74s;

529 (6) A licensed professional counselor; or

530 (7) An advanced practice registered nurse licensed under chapter
531 378.

532 (f) (1) In the case of benefits payable for the services of a licensed
533 physician, such benefits shall be payable for (A) services rendered in a
534 child guidance clinic or residential treatment facility by a person with a
535 master's degree in social work or by a person with a master's degree in
536 marriage and family therapy under the supervision of a psychiatrist,
537 physician, licensed marital and family therapist, or licensed clinical
538 social worker who is eligible for reimbursement under subdivisions (1)
539 to (4), inclusive, of subsection (e) of this section; (B) services rendered
540 in a residential treatment facility by a licensed or certified alcohol and

541 drug counselor who is eligible for reimbursement under subdivision
542 (5) of subsection (e) of this section; or (C) services rendered in a
543 residential treatment facility by a licensed professional counselor who
544 is eligible for reimbursement under subdivision (6) of subsection (e) of
545 this section.

546 (2) In the case of benefits payable for the services of a licensed
547 psychologist under subsection (e) of this section, such benefits shall be
548 payable for (A) services rendered in a child guidance clinic or
549 residential treatment facility by a person with a master's degree in
550 social work or by a person with a master's degree in marriage and
551 family therapy under the supervision of such licensed psychologist,
552 licensed marital and family therapist, or licensed clinical social worker
553 who is eligible for reimbursement under subdivisions (1) to (4),
554 inclusive, of subsection (e) of this section; (B) services rendered in a
555 residential treatment facility by a licensed or certified alcohol and drug
556 counselor who is eligible for reimbursement under subdivision (5) of
557 subsection (e) of this section; or (C) services rendered in a residential
558 treatment facility by a licensed professional counselor who is eligible
559 for reimbursement under subdivision (6) of subsection (e) of this
560 section.

561 (g) In the case of benefits payable for the service of a licensed
562 physician practicing as a psychiatrist or a licensed psychologist, under
563 subsection (e) of this section, such benefits shall be payable for
564 outpatient services rendered (1) in a nonprofit community mental
565 health center, as defined by the Department of Mental Health and
566 Addiction Services, in a nonprofit licensed adult psychiatric clinic
567 operated by an accredited hospital or in a residential treatment facility;
568 (2) under the supervision of a licensed physician practicing as a
569 psychiatrist, a licensed psychologist, a licensed marital and family
570 therapist, a licensed clinical social worker, a licensed or certified
571 alcohol and drug counselor or a licensed professional counselor who is
572 eligible for reimbursement under subdivisions (1) to (6), inclusive, of
573 subsection (e) of this section; and (3) within the scope of the license
574 issued to the center or clinic by the Department of Public Health or to

575 the residential treatment facility by the Department of Children and
576 Families.

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

582 (i) In the case of any person admitted to a state institution or facility
583 administered by the Department of Mental Health and Addiction
584 Services, Department of Public Health, Department of Children and
585 Families or the Department of Developmental Services, the state shall
586 have a lien upon the proceeds of any coverage available to such person
587 or a legally liable relative of such person under the terms of this
588 section, to the extent of the per capita cost of such person's care. Except
589 in the case of emergency services, the provisions of this subsection
590 shall not apply to coverage provided under a managed care plan, as
591 defined in section 38a-478.

592 (j) Reimbursement for covered services rendered in this state by an
593 out-of-network health care provider for the diagnosis or treatment of a
594 substance use disorder shall be paid under the insured's individual
595 health insurance policy directly to the provider if the provider is
596 otherwise eligible for reimbursement for such services. The insured
597 who received such services shall be deemed to have made an
598 assignment to such provider of such insured's coverage
599 reimbursement benefits and other rights under the policy. In no event
600 shall such provider bill, charge, collect a deposit from, seek
601 compensation, remuneration or reimbursement from or have any
602 recourse against the insured for such services, except that such
603 provider may collect any copayments, deductibles or other out-of-
604 pocket expenses that the insured is required to pay under the policy.

605 Sec. 9. Section 38a-514 of the 2018 supplement to the general statutes
606 is repealed and the following is substituted in lieu thereof (*Effective*

607 *January 1, 2019*):

608 (a) For the purposes of this section: (1) "Mental or nervous
609 conditions" means mental disorders, as defined in the most recent
610 edition of the American Psychiatric Association's "Diagnostic and
611 Statistical Manual of Mental Disorders". "Mental or nervous
612 conditions" does not include (A) intellectual disability, (B) specific
613 learning disorders, (C) motor disorders, (D) communication disorders,
614 (E) caffeine-related disorders, (F) relational problems, and (G) other
615 conditions that may be a focus of clinical attention, that are not
616 otherwise defined as mental disorders in the most recent edition of the
617 American Psychiatric Association's "Diagnostic and Statistical Manual
618 of Mental Disorders"; (2) "benefits payable" means the usual,
619 customary and reasonable charges for treatment deemed necessary
620 under generally accepted medical standards, except that in the case of
621 a managed care plan, as defined in section 38a-478, "benefits payable"
622 means the payments agreed upon in the contract between a managed
623 care organization, as defined in section 38a-478, and a provider, as
624 defined in section 38a-478; (3) "acute treatment services" means
625 twenty-four-hour medically supervised treatment for a substance use
626 disorder, that is provided in a medically managed or medically
627 monitored inpatient facility; and (4) "clinical stabilization services"
628 means twenty-four-hour clinically managed postdetoxification
629 treatment, including, but not limited to, relapse prevention, family
630 outreach, aftercare planning and addiction education and counseling.

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

637 (1) General inpatient hospitalization, including in state-operated
638 facilities;

- 639 (2) Medically necessary acute treatment services and medically
640 necessary clinical stabilization services;
- 641 (3) General hospital outpatient services, including at state-operated
642 facilities;
- 643 (4) Psychiatric inpatient hospitalization, including in state-operated
644 facilities;
- 645 (5) Psychiatric outpatient hospital services, including at state-
646 operated facilities;
- 647 (6) Intensive outpatient services, including at state-operated
648 facilities;
- 649 (7) Partial hospitalization, including at state-operated facilities;
- 650 (8) Intensive, home-based services designed to address specific
651 mental or nervous conditions in a child;
- 652 (9) Evidence-based family-focused therapy that specializes in the
653 treatment of juvenile substance use disorders;
- 654 (10) Short-term family therapy intervention;
- 655 (11) Nonhospital inpatient detoxification;
- 656 (12) Medically monitored detoxification;
- 657 (13) Ambulatory detoxification;
- 658 (14) Inpatient services at psychiatric residential treatment facilities;
- 659 (15) Rehabilitation services provided in residential treatment
660 facilities, general hospitals, psychiatric hospitals or psychiatric
661 facilities;
- 662 (16) Observation beds in acute hospital settings;
- 663 (17) Psychological and neuropsychological testing conducted by an

664 appropriately licensed health care provider;

665 (18) Trauma screening conducted by a licensed behavioral health
666 professional;

667 (19) Depression screening, including maternal depression screening,
668 conducted by a licensed behavioral health professional;

669 (20) Substance use screening conducted by a licensed behavioral
670 health professional; and

671 (21) Screening for mental or nervous conditions during any annual
672 physical examination conducted by a licensed physician.

673 (c) No such group policy shall establish any terms, conditions or
674 benefits that place a greater financial burden on an insured for access
675 to diagnosis or treatment of mental or nervous conditions than for
676 diagnosis or treatment of medical, surgical or other physical health
677 conditions, or prohibit an insured from obtaining or a health care
678 provider from being reimbursed for multiple screening services as part
679 of a single-day visit to a health care provider or a multicare institution,
680 as defined in section 19a-490.

681 (d) In the case of benefits payable for the services of a licensed
682 physician, such benefits shall be payable for the same services when
683 such services are lawfully rendered by a psychologist licensed under
684 the provisions of chapter 383 or by such a licensed psychologist in a
685 licensed hospital or clinic.

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

689 (1) A clinical social worker who is licensed under the provisions of
690 chapter 383b and who has passed the clinical examination of the
691 American Association of State Social Work Boards and has completed
692 at least two thousand hours of post-master's social work experience in
693 a nonprofit agency qualifying as a tax-exempt organization under

694 Section 501(c) of the Internal Revenue Code of 1986 or any subsequent
695 corresponding internal revenue code of the United States, as from time
696 to time amended, in a municipal, state or federal agency or in an
697 institution licensed by the Department of Public Health under section
698 19a-490;

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

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

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

711 (5) A licensed alcohol and drug counselor, as defined in section 20-
712 74s, or a certified alcohol and drug counselor, as defined in section 20-
713 74s;

714 (6) A licensed professional counselor; or

715 (7) An advanced practice registered nurse licensed under chapter
716 378.

717 (f) (1) In the case of benefits payable for the services of a licensed
718 physician, such benefits shall be payable for (A) services rendered in a
719 child guidance clinic or residential treatment facility by a person with a
720 master's degree in social work or by a person with a master's degree in
721 marriage and family therapy under the supervision of a psychiatrist,
722 physician, licensed marital and family therapist or licensed clinical
723 social worker who is eligible for reimbursement under subdivisions (1)

724 to (4), inclusive, of subsection (e) of this section; (B) services rendered
725 in a residential treatment facility by a licensed or certified alcohol and
726 drug counselor who is eligible for reimbursement under subdivision
727 (5) of subsection (e) of this section; or (C) services rendered in a
728 residential treatment facility by a licensed professional counselor who
729 is eligible for reimbursement under subdivision (6) of subsection (e) of
730 this section.

731 (2) In the case of benefits payable for the services of a licensed
732 psychologist under subsection (e) of this section, such benefits shall be
733 payable for (A) services rendered in a child guidance clinic or
734 residential treatment facility by a person with a master's degree in
735 social work or by a person with a master's degree in marriage and
736 family therapy under the supervision of such licensed psychologist,
737 licensed marital and family therapist or licensed clinical social worker
738 who is eligible for reimbursement under subdivisions (1) to (4),
739 inclusive, of subsection (e) of this section; (B) services rendered in a
740 residential treatment facility by a licensed or certified alcohol and drug
741 counselor who is eligible for reimbursement under subdivision (5) of
742 subsection (e) of this section; or (C) services rendered in a residential
743 treatment facility by a licensed professional counselor who is eligible
744 for reimbursement under subdivision (6) of subsection (e) of this
745 section.

746 (g) In the case of benefits payable for the service of a licensed
747 physician practicing as a psychiatrist or a licensed psychologist, under
748 subsection (e) of this section, such benefits shall be payable for
749 outpatient services rendered (1) in a nonprofit community mental
750 health center, as defined by the Department of Mental Health and
751 Addiction Services, in a nonprofit licensed adult psychiatric clinic
752 operated by an accredited hospital or in a residential treatment facility;
753 (2) under the supervision of a licensed physician practicing as a
754 psychiatrist, a licensed psychologist, a licensed marital and family
755 therapist, a licensed clinical social worker, a licensed or certified
756 alcohol and drug counselor, or a licensed professional counselor who
757 is eligible for reimbursement under subdivisions (1) to (6), inclusive, of

758 subsection (e) of this section; and (3) within the scope of the license
759 issued to the center or clinic by the Department of Public Health or to
760 the residential treatment facility by the Department of Children and
761 Families.

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

767 (i) In the case of any person admitted to a state institution or facility
768 administered by the Department of Mental Health and Addiction
769 Services, Department of Public Health, Department of Children and
770 Families or the Department of Developmental Services, the state shall
771 have a lien upon the proceeds of any coverage available to such person
772 or a legally liable relative of such person under the terms of this
773 section, to the extent of the per capita cost of such person's care. Except
774 in the case of emergency services the provisions of this subsection shall
775 not apply to coverage provided under a managed care plan, as defined
776 in section 38a-478.

777 (j) A group health insurance policy may exclude the benefits
778 required by this section if such benefits are included in a separate
779 policy issued to the same group by an insurance company, health care
780 center, hospital service corporation, medical service corporation or
781 fraternal benefit society. Such separate policy, which shall include the
782 benefits required by this section and the benefits required by section
783 38a-533, shall not be required to include any other benefits mandated
784 by this title.

785 (k) In the case of benefits based upon confinement in a residential
786 treatment facility, such benefits shall be payable in situations in which
787 the insured has a serious mental or nervous condition that
788 substantially impairs the insured's thoughts, perception of reality,
789 emotional process or judgment or grossly impairs the behavior of the

790 insured, and, upon an assessment of the insured by a physician,
791 psychiatrist, psychologist or clinical social worker, cannot
792 appropriately, safely or effectively be treated in an acute care, partial
793 hospitalization, intensive outpatient or outpatient setting.

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

800 (m) Reimbursement for covered services rendered in this state by an
801 out-of-network health care provider for the diagnosis or treatment of a
802 substance use disorder shall be paid under the insured's group health
803 insurance policy directly to the provider if the provider is otherwise
804 eligible for reimbursement for such services. The insured who received
805 such services shall be deemed to have made an assignment to such
806 provider of such insured's coverage reimbursement benefits and other
807 rights under the policy. In no event shall such provider bill, charge,
808 collect a deposit from, seek compensation, remuneration or
809 reimbursement from or have any recourse against the insured for such
810 services, except that such provider may collect any copayments,
811 deductibles or other out-of-pocket expenses that the insured is
812 required to pay under the policy.

813 Sec. 10. Section 38a-1092 of the general statutes is repealed and the
814 following is substituted in lieu thereof (*Effective January 1, 2019*):

815 (a) Not later than March 31, 2014, and quarterly thereafter, the
816 exchange board of directors shall report to the joint standing
817 committees of the General Assembly having cognizance of matters
818 relating to public health, human services and insurance concerning
819 health care services provided through the exchange. Such reports shall
820 include: (1) The number of persons in households with incomes from
821 one hundred thirty-three per cent up to one hundred fifty per cent of

822 the federal poverty level who were enrolled in a qualified health plan
823 at any time on or after January 1, 2014; (2) the number of persons in
824 households with incomes from one hundred fifty per cent up to and
825 including two hundred per cent of the federal poverty level who were
826 enrolled in a qualified health plan at any time on and after January 1,
827 2014; (3) the number of persons in households with incomes from one
828 hundred thirty-three per cent up to and including two hundred per
829 cent of the federal poverty level who have been continuously enrolled
830 in a qualified health plan during the current calendar year; (4) the
831 number of persons in households with incomes from one hundred
832 thirty-three per cent up to and including two hundred per cent of the
833 federal poverty level who were enrolled in a qualified health plan and
834 who subsequently became eligible to receive benefits under the
835 Medicaid program or whose household income increased to more than
836 two hundred per cent of the federal poverty level; (5) the number of
837 persons in households with incomes from one hundred thirty-three
838 per cent up to and including two hundred per cent of the federal
839 poverty level who experienced a gap in health care coverage; (6) the
840 cost to the state of providing health care services to persons identified
841 in subdivision (5) of this subsection and the cost to such persons to
842 access health care coverage through the exchange; (7) the cost of the
843 second-lowest-priced silver premium plan in the exchange; and (8) any
844 other information that said board believes would be necessary to allow
845 said committees to evaluate the cost and benefits of a basic health plan.

846 (b) The exchange board of directors shall include in the first
847 quarterly report submitted each year to said committees in accordance
848 with subsection (a) of this section, the number of persons in
849 households with incomes from one hundred thirty-three up to and
850 including two hundred per cent of the federal poverty level who were
851 enrolled in a qualified health plan at the end of the previous calendar
852 year.

853 (c) Not later than June 30, 2019, and quarterly thereafter until and
854 including March 31, 2021, the exchange board of directors shall report
855 to the joint standing committees of the General Assembly having

856 cognizance of matters relating to public health and insurance on the
 857 activities the exchange has undertaken and the progress the exchange
 858 has made to have the all-payer claims database provide the data
 859 described in subdivisions (7) to (11), inclusive, of subsection (a) of
 860 section 38a-478c, as amended by this act, and subdivision (1) of
 861 subsection (c) of section 38a-478l, as amended by this act. The report
 862 required under this subsection may be combined with the report
 863 required under subsection (a) of this section, where applicable.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2019</i>	New section
Sec. 2	<i>January 1, 2019</i>	New section
Sec. 3	<i>January 1, 2019</i>	New section
Sec. 4	<i>January 1, 2019</i>	New section
Sec. 5	<i>January 1, 2019</i>	New section
Sec. 6	<i>January 1, 2019</i>	38a-478c
Sec. 7	<i>January 1, 2019</i>	38a-478l
Sec. 8	<i>January 1, 2019</i>	38a-488a
Sec. 9	<i>January 1, 2019</i>	38a-514
Sec. 10	<i>January 1, 2019</i>	38a-1092

Statement of Purpose:

To expand mental health parity requirements, require that health carriers report additional data to the Insurance Department, and require that the Connecticut Health Insurance Exchange submit a report to the General Assembly regarding the all-payer claims database.

[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.]