General Assembly

Raised Bill No. 384

February Session, 2018

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:

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

(1) "Commissioner" means the Insurance Commissioner.

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

(3) "Department" means the Insurance Department.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

govern.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

members of the committee at the hearing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(10) Short-term family therapy intervention;

(11) Nonhospital inpatient detoxification;

(12) Medically monitored detoxification;

(13) Ambulatory detoxification;

(14) Inpatient services at psychiatric residential treatment facilities;

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

(16) Observation beds in acute hospital settings;

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

(18) Trauma screening conducted by a licensed behavioral health

professional;

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

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

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

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

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

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

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

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

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

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

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

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

(6) A licensed professional counselor; or

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

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

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

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

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

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

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

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

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

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

January 1, 2019):

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

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

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

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

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

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

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

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

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

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

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

(10) Short-term family therapy intervention;

(11) Nonhospital inpatient detoxification;

(12) Medically monitored detoxification;

(13) Ambulatory detoxification;

(14) Inpatient services at psychiatric residential treatment facilities;

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

(16) Observation beds in acute hospital settings;

(17) Psychological and neuropsychological testing conducted by an

appropriately licensed health care provider;

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) A licensed professional counselor; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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