



General Assembly

Amendment

February Session, 2018

LCO No. 5197



Offered by:

SEN. KENNEDY, 12th Dist.
SEN. KELLY, 21st Dist.
SEN. LARSON, 3rd Dist.
SEN. FASANO, 34th Dist.
SEN. LOONEY, 11th Dist.
SEN. SOMERS, 18th Dist.

SEN. BYE, 5th Dist.
SEN. HWANG, 28th Dist.
SEN. GERRATANA, 6th Dist.
REP. KUPCHICK, 132nd Dist.
REP. SCANLON, 98th Dist.

To: Subst. Senate Bill No. 384

File No. 338

Cal. No. 210

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

1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

3 "Section 1. (NEW) (*Effective January 1, 2019*) For the purposes of this
4 section and sections 2 to 4, inclusive, of this act:

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

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

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

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

12 (5) "Group health insurance policy" means any group health
13 insurance policy providing coverage of the type specified in
14 subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 of the
15 general statutes.

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

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

24 (8) "Mental health benefits" means covered benefits for any health
25 care services rendered to prevent, evaluate, diagnose or treat one or
26 more mental or nervous conditions.

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

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

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

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

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

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

49 Sec. 3. (NEW) (*Effective January 1, 2019*) (a) On or before March first
50 of each year, each health carrier shall submit to the commissioner and
51 to the joint standing committee of the General Assembly having
52 cognizance of matters relating to insurance a report covering the
53 preceding calendar year. The report shall be on a form prescribed by
54 the commissioner and shall include:

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

64 (B) With respect to claims for physical health benefits the carrier
65 received, and for each category of services set forth in subparagraph
66 (D) of this subdivision, (i) the ratio of the total number of claims for
67 which the carrier required prior authorization to the total number of
68 claims the carrier received, (ii) the ratio of the total number of claims
69 the carrier denied to the total number of claims the carrier received,

70 (iii) the reason the carrier denied any claim, and (iv) the amount of the
71 reimbursement that the carrier paid to the provider who provided
72 such benefits;

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

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

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

99 (3) With respect to each nonquantitative treatment limitation the
100 carrier used during the relevant calendar year, a statement (A)
101 describing the nonquantitative treatment limitation, and (B) disclosing

102 whether the carrier used the nonquantitative treatment limitation with
103 respect to claims for mental health benefits, physical health benefits,
104 substance abuse benefits or any combination thereof;

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

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

113 (b) The commissioner may require that any carrier, in making a
114 report under subsection (a) of this section, disclose information
115 deemed by the carrier to be of a proprietary or competitive nature,
116 provided the commissioner shall maintain the information as
117 confidential and shall not disclose the information to any person
118 except to the extent necessary to carry out the purposes of sections 2 to
119 4, inclusive, of this act. For the purposes of sections 2 to 4, inclusive, of
120 this act, information is of a proprietary or competitive nature if
121 revealing the information would cause the carrier's competitors to
122 obtain valuable business information.

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

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

130 (e) The joint standing committees of the General Assembly having
131 cognizance of matters relating to insurance and public health may
132 require the commissioner to attend an informational hearing following

133 receipt of a report submitted in accordance with the provisions of this
134 section. The commissioner shall attend such informational hearing and
135 be available for questions from members of the committees at the
136 hearing.

137 Sec. 4. (NEW) (*Effective January 1, 2019*) The commissioner may
138 adopt regulations, in accordance with chapter 54 of the general
139 statutes, to implement the provisions of sections 2 and 3 of this act.

140 Sec. 5. Section 38a-478l of the general statutes is repealed and the
141 following is substituted in lieu thereof (*Effective January 1, 2019*):

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

148 (b) (1) The consumer report card shall be known as the "Consumer
149 Report Card on Health Insurance Carriers in Connecticut" and shall
150 include (A) all health care centers licensed pursuant to chapter 698a,
151 (B) the fifteen largest licensed health insurers that use provider
152 networks and that are not included in subparagraph (A) of this
153 subdivision, (C) the state medical loss ratio of each such health care
154 center or licensed health insurer, (D) the federal medical loss ratio of
155 each such health care center or licensed health insurer, (E) the
156 information required under [subdivision] subdivisions (6) and (7) of
157 subsection (a) of section 38a-478c, as amended by this act, and (F) the
158 information [concerning mental health services, as specified in]
159 required under subsection (c) of this section for each such licensed
160 health insurer. The insurers selected pursuant to subparagraph (B) of
161 this subdivision shall be selected on the basis of Connecticut direct
162 written health premiums from such network plans.

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

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

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

175 (c) [With respect to mental health services, the consumer report card
176 shall include information or measures with respect to the percentage of
177 enrollees receiving mental health services, utilization of mental health
178 and chemical dependence services, inpatient and outpatient
179 admissions, discharge rates and average lengths of stay.] (1) On or
180 before May first of each year, each health insurer that provides
181 coverage as set forth in section 38a-488a, as amended by this act, or
182 38a-514, as amended by this act, shall submit to the commissioner:

183 (A) Data for benefit requests, utilization review of benefit requests,
184 adverse determinations and final adverse determinations for the
185 treatment of acute and routine substance use disorders, co-occurring
186 disorders and mental disorders: (i) Grouped according to levels of
187 care, including, but not limited to, inpatient, outpatient, residential
188 care and partial hospitalization; (ii) grouped by category for substance
189 use disorders, co-occurring disorders and mental disorders; and (iii)
190 grouped by children, young adults and adults; and

191 (B) Data for external appeals for the treatment of substance use
192 disorders, co-occurring disorders and mental disorders, grouped in
193 accordance with subparagraphs (A)(i) to (A)(iii), inclusive, of this
194 subdivision.

195 (2) Such data shall be collected in a manner consistent with the
196 National Committee for Quality Assurance Health Plan Employer Data

197 and Information Set measures.

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

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

211 Sec. 6. Section 38a-488a of the 2018 supplement to the general
212 statutes is repealed and the following is substituted in lieu thereof
213 (*Effective January 1, 2019*):

214 (a) For the purposes of this section: (1) "Mental or nervous
215 conditions" means mental disorders, as defined in the most recent
216 edition of the American Psychiatric Association's "Diagnostic and
217 Statistical Manual of Mental Disorders". "Mental or nervous
218 conditions" does not include (A) intellectual disability, (B) specific
219 learning disorders, (C) motor disorders, (D) communication disorders,
220 (E) caffeine-related disorders, (F) relational problems, and (G) other
221 conditions that may be a focus of clinical attention, that are not
222 otherwise defined as mental disorders in the most recent edition of the
223 American Psychiatric Association's "Diagnostic and Statistical Manual
224 of Mental Disorders"; (2) "benefits payable" means the usual,
225 customary and reasonable charges for treatment deemed necessary
226 under generally accepted medical standards, except that in the case of
227 a managed care plan, as defined in section 38a-478, "benefits payable"
228 means the payments agreed upon in the contract between a managed

229 care organization, as defined in section 38a-478, and a provider, as
230 defined in section 38a-478; (3) "acute treatment services" means
231 twenty-four-hour medically supervised treatment for a substance use
232 disorder, that is provided in a medically managed or medically
233 monitored inpatient facility; and (4) "clinical stabilization services"
234 means twenty-four-hour clinically managed postdetoxification
235 treatment, including, but not limited to, relapse prevention, family
236 outreach, aftercare planning and addiction education and counseling.

237 (b) Each individual health insurance policy providing coverage of
238 the type specified in subdivisions (1), (2), (4), (11) and (12) of section
239 38a-469 delivered, issued for delivery, renewed, amended or continued
240 in this state shall provide benefits for the diagnosis and treatment of
241 mental or nervous conditions. Benefits payable include, but need not
242 be limited to:

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

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

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

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

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

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

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

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

- 258 (9) Evidence-based family-focused therapy that specializes in the
259 treatment of juvenile substance use disorders;
- 260 (10) Short-term family therapy intervention;
- 261 (11) Nonhospital inpatient detoxification;
- 262 (12) Medically monitored detoxification;
- 263 (13) Ambulatory detoxification;
- 264 (14) Inpatient services at psychiatric residential treatment facilities;
- 265 (15) Rehabilitation services provided in residential treatment
266 facilities, general hospitals, psychiatric hospitals or psychiatric
267 facilities;
- 268 (16) Observation beds in acute hospital settings;
- 269 (17) Psychological and neuropsychological testing conducted by an
270 appropriately licensed health care provider;
- 271 (18) Trauma screening conducted by a licensed behavioral health
272 professional;
- 273 (19) Depression screening, including maternal depression screening,
274 conducted by a licensed behavioral health professional;
- 275 (20) Substance use screening conducted by a licensed behavioral
276 health professional; and
- 277 (21) Screening for mental or nervous conditions during any annual
278 physical examination conducted by a licensed health care provider.
- 279 (c) No such policy shall establish any terms, conditions or benefits
280 that place a greater financial burden on an insured for access to
281 diagnosis or treatment of mental or nervous conditions than for
282 diagnosis or treatment of medical, surgical or other physical health
283 conditions, or prohibit an insured from obtaining or a health care

284 provider from being reimbursed for multiple screening services as part
285 of a single-day visit to a health care provider or a multicare institution,
286 as defined in section 19a-490.

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

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

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

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

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

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

317 (5) A licensed alcohol and drug counselor, as defined in section 20-
318 74s, or a certified alcohol and drug counselor, as defined in section 20-
319 74s;

320 (6) A licensed professional counselor; or

321 (7) An advanced practice registered nurse licensed under chapter
322 378.

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

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

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

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

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

373 (i) In the case of any person admitted to a state institution or facility
374 administered by the Department of Mental Health and Addiction
375 Services, Department of Public Health, Department of Children and
376 Families or the Department of Developmental Services, the state shall
377 have a lien upon the proceeds of any coverage available to such person
378 or a legally liable relative of such person under the terms of this
379 section, to the extent of the per capita cost of such person's care. Except

380 in the case of emergency services, the provisions of this subsection
381 shall not apply to coverage provided under a managed care plan, as
382 defined in section 38a-478.

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

396 Sec. 7. Section 38a-514 of the 2018 supplement to the general statutes
397 is repealed and the following is substituted in lieu thereof (*Effective*
398 *January 1, 2019*):

399 (a) For the purposes of this section: (1) "Mental or nervous
400 conditions" means mental disorders, as defined in the most recent
401 edition of the American Psychiatric Association's "Diagnostic and
402 Statistical Manual of Mental Disorders". "Mental or nervous
403 conditions" does not include (A) intellectual disability, (B) specific
404 learning disorders, (C) motor disorders, (D) communication disorders,
405 (E) caffeine-related disorders, (F) relational problems, and (G) other
406 conditions that may be a focus of clinical attention, that are not
407 otherwise defined as mental disorders in the most recent edition of the
408 American Psychiatric Association's "Diagnostic and Statistical Manual
409 of Mental Disorders"; (2) "benefits payable" means the usual,
410 customary and reasonable charges for treatment deemed necessary
411 under generally accepted medical standards, except that in the case of
412 a managed care plan, as defined in section 38a-478, "benefits payable"

413 means the payments agreed upon in the contract between a managed
414 care organization, as defined in section 38a-478, and a provider, as
415 defined in section 38a-478; (3) "acute treatment services" means
416 twenty-four-hour medically supervised treatment for a substance use
417 disorder, that is provided in a medically managed or medically
418 monitored inpatient facility; and (4) "clinical stabilization services"
419 means twenty-four-hour clinically managed postdetoxification
420 treatment, including, but not limited to, relapse prevention, family
421 outreach, aftercare planning and addiction education and counseling.

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

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

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

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

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

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

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

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

441 (8) Intensive, home-based services designed to address specific

- 442 mental or nervous conditions in a child;
- 443 (9) Evidence-based family-focused therapy that specializes in the
444 treatment of juvenile substance use disorders;
- 445 (10) Short-term family therapy intervention;
- 446 (11) Nonhospital inpatient detoxification;
- 447 (12) Medically monitored detoxification;
- 448 (13) Ambulatory detoxification;
- 449 (14) Inpatient services at psychiatric residential treatment facilities;
- 450 (15) Rehabilitation services provided in residential treatment
451 facilities, general hospitals, psychiatric hospitals or psychiatric
452 facilities;
- 453 (16) Observation beds in acute hospital settings;
- 454 (17) Psychological and neuropsychological testing conducted by an
455 appropriately licensed health care provider;
- 456 (18) Trauma screening conducted by a licensed behavioral health
457 professional;
- 458 (19) Depression screening, including maternal depression screening,
459 conducted by a licensed behavioral health professional;
- 460 (20) Substance use screening conducted by a licensed behavioral
461 health professional; and
- 462 (21) Screening for mental or nervous conditions during any annual
463 physical examination conducted by a licensed health care provider.
- 464 (c) No such group policy shall establish any terms, conditions or
465 benefits that place a greater financial burden on an insured for access
466 to diagnosis or treatment of mental or nervous conditions than for
467 diagnosis or treatment of medical, surgical or other physical health

468 conditions, or prohibit an insured from obtaining or a health care
469 provider from being reimbursed for multiple screening services as part
470 of a single-day visit to a health care provider or a multicare institution,
471 as defined in section 19a-490.

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

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

480 (1) A clinical social worker who is licensed under the provisions of
481 chapter 383b and who has passed the clinical examination of the
482 American Association of State Social Work Boards and has completed
483 at least two thousand hours of post-master's social work experience in
484 a nonprofit agency qualifying as a tax-exempt organization under
485 Section 501(c) of the Internal Revenue Code of 1986 or any subsequent
486 corresponding internal revenue code of the United States, as from time
487 to time amended, in a municipal, state or federal agency or in an
488 institution licensed by the Department of Public Health under section
489 19a-490;

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

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

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

502 (5) A licensed alcohol and drug counselor, as defined in section 20-
503 74s, or a certified alcohol and drug counselor, as defined in section 20-
504 74s;

505 (6) A licensed professional counselor; or

506 (7) An advanced practice registered nurse licensed under chapter
507 378.

508 (f) (1) In the case of benefits payable for the services of a licensed
509 physician, such benefits shall be payable for (A) services rendered in a
510 child guidance clinic or residential treatment facility by a person with a
511 master's degree in social work or by a person with a master's degree in
512 marriage and family therapy under the supervision of a psychiatrist,
513 physician, licensed marital and family therapist or licensed clinical
514 social worker who is eligible for reimbursement under subdivisions (1)
515 to (4), inclusive, of subsection (e) of this section; (B) services rendered
516 in a residential treatment facility by a licensed or certified alcohol and
517 drug counselor who is eligible for reimbursement under subdivision
518 (5) of subsection (e) of this section; or (C) services rendered in a
519 residential treatment facility by a licensed professional counselor who
520 is eligible for reimbursement under subdivision (6) of subsection (e) of
521 this section.

522 (2) In the case of benefits payable for the services of a licensed
523 psychologist under subsection (e) of this section, such benefits shall be
524 payable for (A) services rendered in a child guidance clinic or
525 residential treatment facility by a person with a master's degree in
526 social work or by a person with a master's degree in marriage and
527 family therapy under the supervision of such licensed psychologist,
528 licensed marital and family therapist or licensed clinical social worker
529 who is eligible for reimbursement under subdivisions (1) to (4),
530 inclusive, of subsection (e) of this section; (B) services rendered in a
531 residential treatment facility by a licensed or certified alcohol and drug

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

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

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

558 (i) In the case of any person admitted to a state institution or facility
559 administered by the Department of Mental Health and Addiction
560 Services, Department of Public Health, Department of Children and
561 Families or the Department of Developmental Services, the state shall
562 have a lien upon the proceeds of any coverage available to such person
563 or a legally liable relative of such person under the terms of this
564 section, to the extent of the per capita cost of such person's care. Except

565 in the case of emergency services the provisions of this subsection shall
566 not apply to coverage provided under a managed care plan, as defined
567 in section 38a-478.

568 (j) A group health insurance policy may exclude the benefits
569 required by this section if such benefits are included in a separate
570 policy issued to the same group by an insurance company, health care
571 center, hospital service corporation, medical service corporation or
572 fraternal benefit society. Such separate policy, which shall include the
573 benefits required by this section and the benefits required by section
574 38a-533, shall not be required to include any other benefits mandated
575 by this title.

576 (k) In the case of benefits based upon confinement in a residential
577 treatment facility, such benefits shall be payable in situations in which
578 the insured has a serious mental or nervous condition that
579 substantially impairs the insured's thoughts, perception of reality,
580 emotional process or judgment or grossly impairs the behavior of the
581 insured, and, upon an assessment of the insured by a physician,
582 psychiatrist, psychologist or clinical social worker, cannot
583 appropriately, safely or effectively be treated in an acute care, partial
584 hospitalization, intensive outpatient or outpatient setting.

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

591 (m) Reimbursement for covered services rendered in this state by an
592 out-of-network health care provider for the diagnosis or treatment of a
593 substance use disorder shall be paid under the insured's group health
594 insurance policy directly to the provider if the provider is otherwise
595 eligible for reimbursement for such services. The insured who received
596 such services shall be deemed to have made an assignment to such

597 provider of such insured's coverage reimbursement benefits and other
598 rights under the policy. In no event shall such provider bill, charge,
599 collect a deposit from, seek compensation, remuneration or
600 reimbursement from or have any recourse against the insured for such
601 services, except that such provider may collect any copayments,
602 deductibles or other out-of-pocket expenses that the insured is
603 required to pay under the policy.

604 Sec. 8. Section 19a-754a of the 2018 supplement to the general
605 statutes is repealed and the following is substituted in lieu thereof
606 (*Effective January 1, 2019*):

607 (a) There is established an Office of Health Strategy, which shall be
608 within the Department of Public Health for administrative purposes
609 only. The department head of said office shall be the executive director
610 of the Office of Health Strategy, who shall be appointed by the
611 Governor in accordance with the provisions of sections 4-5 to 4-8,
612 inclusive, with the powers and duties therein prescribed.

613 (b) On or before July 1, 2018, the Office of Health Strategy shall be
614 responsible for the following:

615 (1) Developing and implementing a comprehensive and cohesive
616 health care vision for the state, including, but not limited to, a
617 coordinated state health care cost containment strategy;

618 (2) Directing and overseeing (A) the all-payers claims database
619 program established pursuant to section 19a-755a, and (B) the State
620 Innovation Model Initiative and related successor initiatives;

621 (3) Coordinating the state's health information technology
622 initiatives;

623 (4) Directing and overseeing the Office of Health Care Access and
624 all of its duties and responsibilities as set forth in chapter 368z; and

625 (5) Convening forums and meetings with state government and
626 external stakeholders, including, but not limited to, the Connecticut

627 Health Insurance Exchange, to discuss health care issues designed to
628 develop effective health care cost and quality strategies.

629 (c) Not later than June 30, 2019, and quarterly thereafter until and
630 including March 31, 2021, the Office of Health Strategy shall report to
631 the joint standing committees of the General Assembly having
632 cognizance of matters relating to public health and insurance on the
633 activities the office has undertaken and the progress the office has
634 made to have the all-payer claims database, as defined in section 19a-
635 755a, provide the data described in subdivisions (7) to (11), inclusive,
636 of subsection (a) of section 38a-478c, as amended by this act, and
637 subdivision (1) of subsection (c) of section 38a-478l, as amended by this
638 act.

639 ~~[(c)]~~ (d) The Office of Health Strategy shall constitute a successor, in
640 accordance with the provisions of sections 4-38d, 4-38e and 4-39, to the
641 functions, powers and duties of the following:

642 (1) The Connecticut Health Insurance Exchange, established
643 pursuant to section 38a-1081, relating to the administration of the all-
644 payer claims database pursuant to section 19a-755a; and

645 (2) The Office of the Lieutenant Governor, relating to the (A)
646 development of a chronic disease plan pursuant to section 19a-6q, (B)
647 housing, chairing and staffing of the Health Care Cabinet pursuant to
648 section 19a-725, and (C) (i) appointment of the health information
649 technology officer pursuant to section 19a-755, and (ii) oversight of the
650 duties of such health information technology officer as set forth in
651 sections 17b-59, 17b-59a and 17b-59f.

652 ~~[(d)]~~ (e) Any order or regulation of the entities listed in subdivisions
653 (1) and (2) of subsection ~~[(c)]~~ (d) of this section that is in force on July 1,
654 2018, shall continue in force and effect as an order or regulation until
655 amended, repealed or superseded pursuant to law."

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>	38a-478l
Sec. 6	<i>January 1, 2019</i>	38a-488a
Sec. 7	<i>January 1, 2019</i>	38a-514
Sec. 8	<i>January 1, 2019</i>	19a-754a