General Assembly

# *Amendment*

***February Session, 2018***

LCO No. **5197**

* S B 0 0 3 8 4 0 5 1 9 7 S D O *

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."***

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

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

(7) "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.

(8) "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.

(9) "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.

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

(11) "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.

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

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

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 and to the joint standing committee of the General Assembly having cognizance of matters relating to insurance 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, and (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;

(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 2 to 4, inclusive, of this act. For the purposes of sections 2 to 4, 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.

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

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

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

Sec. 5. 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; and

(B) Data for external appeals for the treatment of substance use disorders, co-occurring disorders and mental disorders, grouped in accordance with 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. 6. 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 health care provider.

(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. 7. 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 health care provider.

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

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

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

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

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

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

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

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

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

(c) Not later than June 30, 2019, and quarterly thereafter until and including March 31, 2021, the Office of Health Strategy 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 office has undertaken and the progress the office has made to have the all-payer claims database, as defined in section 19a-755a, 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.

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

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

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

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

| 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* | 38a-478*l* |
| Sec. 6 | *January 1, 2019* | 38a-488a |
| Sec. 7 | *January 1, 2019* | 38a-514 |
| Sec. 8 | *January 1, 2019* | 19a-754a |