Senate

General Assembly

File No. 449

January Session, 2015

Senate Bill No. 1085

Senate, April 2, 2015

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR MENTAL OR NERVOUS CONDITIONS.

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

Section 1. Section 38a-488a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2016*):

(a) **[**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.**]** For the purposes of this section: **[**, "mental or nervous conditions"**]** (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 **[**(1)**]** (A) intellectual disabilities, **[**(2)**]** (B) specific learning disorders, **[**(3)**]** (C) motor disorders, **[**(4)**]** (D) communication disorders, **[**(5)**]** (E) caffeine-related disorders, **[**(6)**]** (F) relational problems, and **[**(7)**]** (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"; **[**, except that coverage for an insured under such policy who has been diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" shall be provided in accordance with subsection (b) of section 38a-488b.**]** (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) (1) 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:

(A) General inpatient hospitalization, including in state-operated facilities, without prior authorization for up to fourteen days of inpatient hospital treatment for acute treatment services and clinical stabilization services;

(B) Medically necessary acute treatment services and medically necessary clinical stabilization services without prior authorization for

up to fourteen days;

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

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

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

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

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

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

(I) Intensive, home-based services designed to address specific mental or nervous conditions in a child while remediating problematic parenting practices and addressing other family and educational challenges that affect the child's and family's ability to function;

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

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

(L) Short-term family therapy intervention and juvenile diversion programs that target at-risk children to address adolescent behavior

problems, conduct disorders, substance use disorders and delinquency;

(M) Other home-based therapeutic interventions for children;

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

(O) Nonhospital inpatient detoxification;

(P) Medically monitored detoxification;

(Q) Ambulatory detoxification;

(R) Inpatient services at psychiatric residential treatment facilities;

(S) Extended day treatment programs, as described in section 17a-22;

(T) Rehabilitation services provided in a licensed group home or in a community-based setting;

(U) Rehabilitation services provided in residential treatment facilities;

(V) Observation beds in acute hospital settings;

(W) Emergency mobile psychiatric services;

(X) Case management conducted by a licensed health care provider, including care coordination, communication and treatment planning with other health care providers, necessary to ensure adequate and appropriate treatment for a diagnosed mental or nervous condition;

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

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

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

(BB) Substance use screening conducted by a licensed behavioral health professional.

(2) With respect to the benefits required under subparagraphs (A) and (B) of subdivision (1) of this subsection, the facility at which such hospitalization or treatment is provided shall, not later than forty-eight hours after the insured's admission for such hospitalization or treatment, notify the issuer of the policy of such admission and provide an initial treatment plan to such issuer. Such issuer may initiate utilization review procedures for such hospitalization or treatment on or after the seventh day after such hospitalization or treatment commences.

[(b)**]** (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.

[(c)**]** (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.

[(d)**]** (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; **[**or**]**

(6) A licensed professional counselor; or

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

[(e) For purposes of this section, the term "covered expenses" 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, "covered expenses" 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.**]**

(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 **[**(d)**]** (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 **[**(d)**]** (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 **[**(d)**]** (e) of this section.

(2) In the case of benefits payable for the services of a licensed psychologist under subsection **[**(d)**]** (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 **[**(d)**]** (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 **[**(d)**]** (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 **[**(d)**]** (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 **[**(d)**]** (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 **[**(d)**]** (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.

Sec. 2. Section 38a-514 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2016*):

(a) **[**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.**]** For the purposes of this section: **[**, "mental or nervous conditions"**]** (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 **[**(1)**]** (A) intellectual disabilities, **[**(2)**]** (B) specific learning disorders, **[**(3)**]** (C) motor disorders, **[**(4)**]** (D) communication disorders, **[**(5)**]** (E) caffeine-related disorders, **[**(6)**]** (F) relational problems, and **[**(7)**]** (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"; **[**, except that coverage for an insured under such policy who has been diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" shall be provided in accordance with subsection (i) of section 38a-514b.**]** (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) (1) 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:

(A) General inpatient hospitalization, including in state-operated facilities, without prior authorization for up to fourteen days of inpatient hospital treatment for acute treatment services and clinical stabilization services;

(B) Medically necessary acute treatment services and medically necessary clinical stabilization services without prior authorization for up to fourteen days;

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

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

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

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

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

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

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

mental or nervous conditions in a child while remediating problematic parenting practices and addressing other family and educational challenges that affect the child's and family's ability to function;

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

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

(L) Short-term family therapy intervention and juvenile diversion programs that target at-risk children to address adolescent behavior problems, conduct disorders, substance use disorders and delinquency;

(M) Other home-based therapeutic interventions for children;

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

(O) Nonhospital inpatient detoxification;

(P) Medically monitored detoxification;

(Q) Ambulatory detoxification;

(R) Inpatient services at psychiatric residential treatment facilities;

(S) Extended day treatment programs, as described in section 17a-22;

(T) Rehabilitation services provided in a licensed group home or in a community-based setting;

(U) Rehabilitation services provided in residential treatment facilities;

(V) Observation beds in acute hospital settings;

(W) Emergency mobile psychiatric services;

(X) Case management conducted by a licensed health care provider, including care coordination, communication and treatment planning with other health care providers, necessary to ensure adequate and appropriate treatment for a diagnosed mental or nervous condition;

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

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

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

(BB) Substance use screening conducted by a licensed behavioral health professional.

(2) With respect to the benefits required under subparagraphs (A) and (B) of subdivision (1) of this subsection, the facility at which such hospitalization or treatment is provided shall, not later than forty-eight hours after the insured's admission for such hospitalization or treatment, notify the issuer of the policy of such admission and provide an initial treatment plan to such issuer. Such issuer may initiate utilization review procedures for such hospitalization or treatment on or after the seventh day after such hospitalization or treatment commences.

[(b)**]** (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.

[(c)**]** (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.

[(d)**]** (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; **[**or**]**

(6) A licensed professional counselor; or

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

[(e) For purposes of this section, the term "covered expenses" 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, "covered expenses" 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.**]**

(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 **[**(d)**]** (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 **[**(d)**]** (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 **[**(d)**]** (e) of this section.

(2) In the case of benefits payable for the services of a licensed psychologist under subsection **[**(d)**]** (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 **[**(d)**]** (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 **[**(d)**]** (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 **[**(d)**]** (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 **[**(d)**]** (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 **[**(d)**]** (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.

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

Section 1	*January 1, 2016*	38a-488a
Sec. 2	*January 1, 2016*	38a-514

INS *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 16 $	FY 17 $
State Comptroller - Fringe Benefits (State Employee Active and Retiree Health Accounts)	GF, TF - Cost	See Below	See Below
The State	Cost	See Below	See Below

Note: GF=General Fund and TF = Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 16 $	FY 17 $
Various Municipalities	STATE MANDATE - Cost	See Below	See Below

Explanation

The bill will result in a cost to the state employee and retiree health plan[1], municipalities, and the state, related to expanding the scope of mental health services required to be covered. The state plan provides coverage for many of the services specified in the bill and requires prior authorization for all covered services except for psychological and neuropsychological testing, trauma, depression, and substance use screenings. In general, the state plan does not provide coverage for the following services: treatment in a group-home, emergency mobile psychiatric services, or case management. Secondly, the bill requires coverage for inpatient hospitalization and medically necessary acute treatment and clinical stabilization services for up to 14 days without prior authorization. The state plan currently provides coverage for

[1] The state employee and retiree health plan is a self-insured health plan. Pursuant to federal law, self-insured health plans are exempt from state health mandates. However, the state has traditionally adopted all state health mandates.

inpatient hospitalization and clinical stabilization, but requires prior authorization for coverage. The bill also requires coverage for multiple screening services as part of a single visit to a provider or multicare institution. Lastly, the bill requires coverage of services for mental and nervous conditions provided by an APRN, which is not anticipated to result in a fiscal impact.

The cost to the state to expand coverage to include those services not currently covered will result in the following:

- Treatment in group homes will cost approximately $550,000 in FY 16 and $1.1 million in FY 17[2];
- Emergency Mobile Psychiatric Services will depend on the rate negotiated for the private plan and the utilization of services;
- Case management will depend on the rate negotiated for the private plan and the utilization of services. The average rate for the state's public programs is approximately $10.50 per 15 minute interval;
- Up to 14 day inpatient hospitalization, medically necessary acute treatment services, and medically necessary clinical stabilization services without prior authorization will depend on the extent to which care is provided that otherwise would not have been provided under the current prior authorization requirements. For reference the state health plan spent approximately $13.8 million in FY 14 on inpatient mental health and substance use services. Inpatient hospitalization represented $9 million. Each 2% increase in inpatient hospitalization is approximately $180,000; and
- To the extent that multiple screenings, for a single visit, are

[2] Estimate is based on FY 14 paid claims experience for coverage provided for the state health plan by Oxford and assumes a per member per month (PMPM) of $0.51 for the portion of the state plan population covered by Anthem.

billed separately, as opposed to being bundled into a single payment for the episode, there will be an additional cost to the state plan of approximately $25,000 in FY 16 and $50,000 in FY 17.[3]

Lastly, the cost to the state pursuant to the federal Affordable Care Act (ACA) (See Background) will depend on which services are determined to be expanded services. Current law requires health plans to cover the diagnosis of and treatment for mental and nervous conditions on the same basis as for medical, surgical, or other physical conditions, but does not specify the services in the same manner as the bill.

Municipal Impact

As previously stated, the bill may increase costs to certain fully insured municipal plans which do not provide coverage for the services enumerated in the bill or not to the extent required by the bill. The coverage requirements may result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2016. In addition, many municipal health plans are recognized as "grandfathered" health plans under the ACA.[4] It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA. Pursuant to federal law, self-insured health plans are exempt from state health mandates.

Background: The State and the federal ACA

Lastly, the ACA requires that, the state's health exchange's qualified health plans (QHPs)[5], include a federally defined essential health

[3] The estimated cost is based on the PMPM impact of $0.02. The cost estimate for the state employee plan is based on the plan membership as of January 2015.
[4] Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010.
[5] The state's health exchange, Access Health CT, opened its marketplace for Connecticut residents to purchase QHPs from carriers, with coverage starting January 1, 2014.

benefits package (EHB). The federal government is allowing states to choose a benchmark plan[6] to serve as the EHB until 2016 when the federal government is anticipated to revisit the EHB.

While states are allowed to mandate benefits in excess of the EHB, the federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the exchange, by reimbursing the carrier or the insured for the excess coverage. State mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB for 2014-2015 unless they are already part of the benchmark plan.[7] However, neither the agency nor the mechanism for the state to pay these costs has been established.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to (1) medical inflation, (2) the number of members in the state and municipal health plans, and exchange health plans, and (3) the utilization of services.

Sources: *State of Connecticut Benefit Plan Document as of January 1, 2015*
Office of the State Comptroller
Dept. of Social Services Website (Public Program Reimbursement Rates)

[6] The state's benchmark plan is the Connecticare HMO plan with supplemental coverage for pediatric dental and vision care as required by the ACA.
[7] *Source*: Dept. of Health and Human Services. *Frequently Asked Questions on Essential Health Benefits Bulletin* (February 21, 2012).

OLR Bill Analysis

SB 1085

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR MENTAL OR NERVOUS CONDITIONS.

SUMMARY:

This bill expands the services certain health insurance policies must cover for mental and nervous conditions (see BACKGROUND). By law, a policy must cover the diagnosis of and treatment for mental or nervous conditions on the same basis as for medical, surgical, or other physical conditions (i.e., parity).

The bill requires insurers to cover, among other things:

1. certain acute (e.g., substance use disorder) treatment and clinical stabilization (e.g., postdetoxification) services for up to 14 days without preauthorization;

2. services provided by advanced practice registered nurses (APRNs) for mental and nervous conditions; and

3. programs to improve health outcomes for mothers, children, and families.

Under the bill, a policy cannot prohibit an insured from getting, or a provider getting reimbursed for, multiple screening services as part of a single-day visit to a health care provider or multicare institution (e.g., hospital, psychiatric outpatient clinic, or free standing facility for substance use treatment).

The bill substitutes the term "benefits payable" for "covered expenses" as it pertains to the mental or nervous conditions coverage provisions. By law, these are the usual, customary, and reasonable charges for medically necessary treatment or, in the case of a managed

care plan, the contracted rates.

The bill also makes technical and conforming changes.

The bill applies to individual and group health insurance policies issued, delivered, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, or (4) hospital or medical services, including those provided through an HMO. Due to the federal Employee Retirement Income Security Act, state insurance mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2016

COVERAGE FOR MENTAL OR NERVOUS CONDITIONS

Under the bill, insurers' coverage for mental or nervous conditions must include:

1. general hospital outpatient services,
2. psychiatric inpatient hospitalization and outpatient hospital services,
3. intensive outpatient services, and
4. partial hospitalization.

The bill specifies that these services may be provided at state-operated facilities.

The bill requires insurers to also cover:

1. evidence based maternal, infant, and early childhood home visitation services designed to improve health outcomes for pregnant women, postpartum mothers, and newborns and children, including maternal substance use disorders or depression and relationship-focused interventions for children with mental or nervous conditions or substance use disorders;

2. intensive, home-based services addressing specific mental or nervous conditions in a child while remediating problematic parenting practices and addressing other family and educational challenges that affect the child's and family's ability to function;

3. intensive, family- and community-based treatment programs that focus on environmental systems impacting chronic and violent juvenile offenders;

4. evidence-based family-focused therapy specializing in the treatment of juvenile substance use disorders and delinquency;

5. short-term family therapy intervention and juvenile diversion programs targeting at-risk children to address adolescent behavior problems, conduct disorders, substance use disorders, and delinquency;

6. other home-based therapeutic interventions for children;

7. chemical maintenance treatment (i.e., when a person is admitted for the planned use of a prescribed substance under medical supervision);

8. nonhospital inpatient, medically monitored, or ambulatory detoxification;

9. inpatient services at psychiatric residential treatment facilities;

10. extended day treatment programs for emotionally disturbed, mentally ill, behaviorally disordered, or multiply handicapped children and youth;

11. rehabilitation services provided in a licensed group home, community setting, or residential treatment facility;

12. observation beds in acute hospital settings;

13. emergency mobile psychiatric services;

14. case management by a licensed health care provider, including care coordination, communication, and treatment planning with other providers necessary to ensure adequate and appropriate treatment for an insured diagnosed with a mental or nervous condition;

15. psychological and neuropsychological testing by an appropriately licensed health care provider;

16. trauma screening by a licensed behavioral health professional;

17. depression screening, including maternal depression screening, by a licensed behavioral health professional; and

18. substance use screening by a licensed behavior health professional.

Acute Treatment and Clinical Stabilization Services without Prior Authorization

The bill also requires insurers to cover certain acute treatment and clinical stabilization services. "Acute treatment" is 24-hour medically supervised treatment for a substance use disorder provided in a medically managed or medically monitored inpatient facility. "Clinical stabilization" is 24-hour clinically managed postdetoxification treatment, including relapse prevention, family outreach, aftercare planning, and addiction education and counseling.

Under the bill, insurers must cover general inpatient hospitalization, including at state-operated facilities, and medically necessary services for up to 14 days without preauthorization for acute treatment and clinical stabilization services.

The bill requires the treating facility to, within 48 hours after the insured's admission, notify the insured's insurer of his or her admission and provide an initial treatment plan. The insurer may begin utilization review procedures seven days after the insured is admitted or begins treatment. (Utilization review is a health carrier's review of a covered person's benefits with respect to a certain medical

service).

COVERAGE FOR SERVICES PROVIDED BY AN APRN

The bill requires insurers to cover services for mental or nervous conditions provided by an APRN.

By law, insurers must already cover services provided by a licensed physician, psychologist, clinical social worker, marital and family therapist, or professional counselor. Existing law also covers services from certain certified marital and family therapists and independent social workers, as well as with licensed or certified alcohol and drug counselors.

BACKGROUND

Mental or Nervous Conditions

By law, "mental or nervous conditions" are mental disorders defined in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). This does not include (1) intellectual disabilities, (2) specific learning disorders, (3) motor disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) other conditions that may be a focus of clinical attention but are not defined as mental disorders in the DSM (CGS §§ 38a-488a & 38a-514).

Related Federal Law

Under the federal Patient Protection and Affordable Care Act (P.L. 111-148), a state may require health plans sold through the state's health insurance exchange to offer benefits beyond those included in the required "essential health benefits," provided the state defrays the cost of those additional benefits. The requirement applies to benefit mandates a state enacts after December 31, 2011. Thus, the state must pay the insurance carrier or enrollee to defray the cost of any new benefits mandated after that date.

Related Bills

sHB 6847, favorably reported by the Insurance and Real Estate

Committee, expands coverage for autism spectrum disorder (ASD). ASD is a mental and nervous condition covered under the provisions of this bill.

SB 16, favorably reported by the Insurance and Real Estate Committee, prohibits insurers from limiting the number of visits to assess an insured for a mental or nervous condition diagnosis, and requires insurers to cover certain consultations.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 19 Nay 0 (03/19/2015)