General Assembly

Raised Bill No. 1085

January Session, 2015

LCO No. **5095**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

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 Section 38a-488a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2016*):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