S T A T E O F N E W Y O R K

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I N A S S E M B L Y

June 2, 2014

Introduced by COMMITTEE ON RULES -- (at request of M. of A. Cusick, Weisenberg, Ortiz, Gunther, Skoufis, Rosenthal, Titone, Mosley, Peoples-Stokes, Galef, Barrett, Gottfried, Fahy, Braunstein, Camara, Cook, Hooper, Magee, O'Donnell, Rivera, Saladino, Sweeney, Thiele) -- read once and referred to the Committee on Insurance -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- again reported from said committee with amendments, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the insurance law and the public health law, in relation to requiring health insurance coverage for diagnosis and treatment of substance use disorder treatment services and creating a workgroup to study and make recommendations

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Subsection (i) of section 3216 of the insurance law is amended by adding a new paragraph 30 to read as follows:

(30) (A) EVERY POLICY THAT PROVIDES MEDICAL, MAJOR-MEDICAL OR SIMILAR COMPREHENSIVE-TYPE COVERAGE SHALL INCLUDE COVERAGE FOR DIAGNOSIS AND TREATMENT OF SUBSTANCE USE DISORDER BENEFITS PURSUANT TO THE FEDERAL PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008, AS AMENDED, OR OTHER APPLICABLE FEDERAL AND STATE STATUTES AND RULES AND REGULATIONS PROMULGATED THERETO WHICH REQUIRE PARITY BETWEEN MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS AND MEDICAL/SURGICAL BENEFITS WITH RESPECT TO FINANCIAL REQUIREMENTS AND TREATMENT OR WHICH REQUIRE COVERAGE OF SUCH TREATMENT, WHICHEVER PROVIDES A BENEFIT THAT IS MORE ADVANTAGEOUS TO THE POLICYHOLDER AS DETERMINED BY THE SUPERINTENDENT. SUCH COVERAGE SHALL INCLUDE BOTH INPATIENT AND OUTPATIENT TREATMENT, INCLUDING DETOXIFICATION AND REHABILITATION SERVICES.

(B) IN THE EVENT OF AN ADVERSE DETERMINATION FOR SUBSTANCE USE DISORDER TREATMENT SERVICES, THE HEALTH PLAN SHALL CONTINUE TO PROVIDE COVERAGE AND REIMBURSE FOR ALL SUCH SERVICES UNTIL THE INSURED HAS EXHAUSTED ALL APPEALS, BOTH INTERNAL AND EXTERNAL, OR OTHERWISE NOTIFIES THE HEALTH PLAN IN WRITING THAT HE OR SHE HAS DECIDED TO NOT MOVE FORWARD

EXPLANATION--Matter in ITALICS (underscored) is new; matter in brackets [ ] is old law to be omitted.

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WITH THE APPEALS PROCESS. THE HEALTH PLAN SHALL ENSURE THAT AN INSURED SHALL NOT INCUR ANY GREATER OUT-OF-POCKET COSTS FOR SUBSTANCE USE DISORDER TREATMENT SERVICES RENDERED WHILE THE PROVIDER IS APPEALING AN ADVERSE DETERMINATION FOR SUCH SERVICES THAN THE INSURED WOULD HAVE INCURRED IF SUCH SERVICES WERE APPROVED BY THE UTILIZATION REVIEW AGENT.

S 2. Subsection (l) of section 3221 of the insurance law is amended by adding a new paragraph 19 to read as follows:

(19) (A) EVERY GROUP OR BLANKET POLICY DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE WHICH PROVIDES MAJOR MEDICAL OR SIMILAR COMPREHENSIVE-TYPE COVERAGE SHALL INCLUDE SPECIFIC COVERAGE FOR DIAGNOSIS AND TREATMENT OF SUBSTANCE USE DISORDER BENEFITS PURSUANT TO THE FEDERAL PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008, AS AMENDED, OR OTHER APPLICABLE FEDERAL AND STATE STATUTES AND RULES AND REGULATIONS PROMULGATED THERETO WHICH REQUIRE PARITY BETWEEN MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS AND MEDICAL/SURGICAL BENEFITS WITH RESPECT TO FINANCIAL REQUIREMENTS AND TREATMENT OR WHICH REQUIRE COVERAGE OF SUCH TREATMENT, WHICHEVER PROVIDES A BENEFIT THAT IS MORE ADVANTAGEOUS TO THE POLICYHOLDER AS DETERMINED BY THE SUPERINTENDENT. SUCH COVERAGE SHALL INCLUDE BOTH INPATIENT AND OUTPATIENT TREATMENT, INCLUDING DETOXIFICATION AND REHABILITATION SERVICES.

(B) IN THE EVENT OF AN ADVERSE DETERMINATION FOR CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER TREATMENT SERVICES, THE HEALTH PLAN SHALL CONTINUE TO PROVIDE COVERAGE AND REIMBURSE FOR ALL SUCH SERVICES UNTIL THE INSURED HAS EXHAUSTED ALL APPEALS, BOTH INTERNAL AND EXTERNAL, OR OTHERWISE NOTIFIES THE HEALTH PLAN IN WRITING THAT HE OR SHE HAS DECIDED TO NOT MOVE FORWARD WITH THE APPEALS PROCESS. THE HEALTH PLAN SHALL ENSURE THAT AN INSURED SHALL NOT INCUR ANY GREATER OUT-OF-POCKET COSTS FOR SUBSTANCE USE DISORDER TREATMENT SERVICES RENDERED WHILE THE PROVIDER IS APPEALING AN ADVERSE DETERMINATION FOR SUCH SERVICES THAN THE INSURED WOULD HAVE INCURRED IF SUCH SERVICES WERE APPROVED BY THE UTILIZATION REVIEW AGENT.

S 3. Section 4303 of the insurance law is amended by adding a new subsection (oo) to read as follows:

(OO) (1) A MEDICAL EXPENSE INDEMNITY CORPORATION, A HOSPITAL SERVICE CORPORATION OR A HEALTH SERVICE CORPORATION WHICH PROVIDES MAJOR MEDICAL OR SIMILAR COMPREHENSIVE-TYPE COVERAGE SHALL INCLUDE SPECIFIC COVERAGE FOR DIAGNOSIS AND TREATMENT OF SUBSTANCE USE DISORDER BENEFITS PURSUANT TO THE FEDERAL PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008, AS AMENDED, OR OTHER APPLICABLE FEDERAL AND STATE STATUTES AND RULES AND REGULATIONS PROMULGATED THERETO WHICH REQUIRE PARITY BETWEEN MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS AND MEDICAL/SURGICAL BENEFITS WITH RESPECT TO FINANCIAL REQUIREMENTS AND TREATMENT OR WHICH REQUIRE COVERAGE OF SUCH TREATMENT, WHICHEVER PROVIDES A BENEFIT THAT IS MORE ADVANTAGEOUS TO THE POLICYHOLDER AS DETERMINED BY THE SUPERINTENDENT. SUCH COVERAGE SHALL INCLUDE BOTH INPATIENT AND OUTPATIENT TREATMENT, INCLUDING DETOXIFICATION AND REHABILITATION SERVICES.

(2) IN THE EVENT OF AN ADVERSE DETERMINATION FOR CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER TREATMENT SERVICES, THE HEALTH PLAN SHALL CONTINUE TO PROVIDE COVERAGE AND REIMBURSE FOR ALL SUCH SERVICES UNTIL THE INSURED HAS EXHAUSTED ALL APPEALS, BOTH INTERNAL AND EXTERNAL, OR OTHERWISE NOTIFIES THE HEALTH PLAN IN WRITING THAT HE OR SHE HAS DECIDED TO NOT MOVE FORWARD WITH THE APPEALS PROCESS. THE HEALTH PLAN SHALL ENSURE THAT AN INSURED SHALL NOT INCUR ANY GREATER OUT-OF POCKET COSTS FOR SUBSTANCE USE DISORDER TREATMENT SERVICES RENDERED WHILE THE PROVID-

ER IS APPEALING AN ADVERSE DETERMINATION FOR SUCH SERVICES THAN THE INSURED WOULD HAVE INCURRED IF SUCH SERVICES WERE APPROVED BY THE UTILIZATION REVIEW AGENT.

S 4. Section 4902 of the insurance law is amended by adding two new subsections (c) and (d) to read as follows:

(C) I. WHEN CONDUCTING A UTILIZATION REVIEW FOR PURPOSES OF DETERMINING HEALTH CARE COVERAGE FOR CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDERS, A UTILIZATION REVIEW AGENT SHALL BE A HEALTH CARE PROVIDER WHO SPECIALIZES IN BEHAVIORAL HEALTH AND WHO HAS EXPERIENCE IN THE DELIVERY OF CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER COURSES OF TREATMENT TO SUPERVISE AND OVERSEE THE MEDICAL MANAGEMENT DECISIONS RELATING TO SUCH TREATMENT.

II. A UTILIZATION REVIEW AGENT SHALL UTILIZE RECOGNIZED EVIDENCE-BASED AND PEER REVIEWED CLINICAL REVIEW CRITERIA THAT IS APPROPRIATE TO THE AGE OF THE PATIENT AND IS DEEMED APPROPRIATE AND APPROVED FOR SUCH USE BY THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE SUPERINTENDENT.

III. THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE SUPERINTENDENT SHALL APPROVE A RECOGNIZED EVIDENCE-BASED AND PEER REVIEWED CLINICAL REVIEW CRITERIA, IN ADDITION TO ANY OTHER APPROVED EVIDENCE-BASED AND PEER REVIEWED CLINICAL REVIEW CRITERIA.

(D) WHERE AN INSURED'S HEALTHCARE PROVIDER BELIEVES AN IMMEDIATE APPEAL OF AN ADVERSE DETERMINATION FOR TREATMENT RELATING TO CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER IS WARRANTED, ALL INTERNAL APPEALS SHALL BE CONDUCTED ON AN EXPEDITED BASIS AS SET FORTH IN SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS ARTICLE. WHERE AN INSURED'S HEALTH CARE PROVIDER DETERMINES THAT A DELAY IN PROVIDING CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER TREATMENT WOULD POSE A SERIOUS THREAT TO THE HEALTH OR SAFETY OF THE INSURED, EXTERNAL APPEALS OF UTILIZATION REVIEW DETERMINATION WILL BE CONDUCTED ON AN EXPEDITED BASIS AS SET FORTH IN PARAGRAPH THREE OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS ARTICLE.

S 5. Subsection (c) of section 4903 of the insurance law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

(c) A utilization review agent shall make a determination involving continued or extended health care services, additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, REQUESTS FOR TREATMENT FOR CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission OR REQUESTS FOR TREATMENT FOR CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date. Provided that a request for home health care services and all necessary information is submitted to the utilization review agent prior to discharge from an inpatient hospital admission pursuant to this subsection, a utilization review agent shall not deny, on the basis of

medical necessity or lack of prior authorization, coverage for home health care services while a determination by the utilization review agent is pending. PROVIDED THAT A REQUEST FOR TREATMENT FOR CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER AND ALL NECESSARY INFORMATION IS SUBMITTED TO THE UTILIZATION REVIEW AGENT PURSUANT TO THIS SUBSECTION, A UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, COVERAGE FOR CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER TREATMENT WHILE A DETERMINATION BY THE UTILIZATION REVIEW AGENT IS PENDING. PROVIDED THAT UPON ADMISSION TO INPATIENT AND RESIDENTIAL TREATMENT FOR CHEMICAL DEPENDENCY OR SUBSTANCE USE DISORDER, THE UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, WHEN NOTICE OF ADMISSION FOR PURPOSES OF CARE COORDINATION WAS PROVIDED TO THE UTILIZATION REVIEW AGENT WITHIN TWENTY-FOUR HOURS OF AN ADMISSION; AND A REQUEST FOR TREATMENT FOR CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER AND ALL NECESSARY INFORMATION IS SUBMITTED TO THE UTILIZATION REVIEW AGENT PURSUANT TO THIS SUBSECTION.

S 6. Subsection (b) of section 4904 of the insurance law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

(b) A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving (1) continued or extended health care services, procedures or treatments or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider or home health care services following discharge from an inpatient hospital admission pursuant to subsection (c) of section four thousand nine hundred three of this article or (2) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination. Such process shall include mechanisms which facilitate resolution of the appeal including but not limited to the sharing of information from the insured's health care provider and the utilization review agent by telephonic means or by facsimile. The utilization review agent shall provide reasonable access to its clinical peer reviewer within one business day of receiving notice of the taking of an expedited appeal. Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process pursuant to section four thousand nine hundred fourteen of this article as applicable. PROVIDED THAT THE INSURED OR THE INSURED'S HEALTH CARE PROVIDER NOTIFIES THE UTILIZATION REVIEW AGENT OF ITS INTENT TO FILE AN EXTERNAL APPEAL IMMEDIATELY UPON RECEIPT OF AN APPEAL DETERMINATION AND A REQUEST FOR AN EXPEDITED EXTERNAL APPEAL FOR TREATMENT OF CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER AND ALL NECESSARY INFORMATION IS SUBMITTED WITHIN TWENTY-FOUR HOURS OF RECEIPT OF AN APPEAL DETERMINATION, A UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, COVERAGE FOR SUCH TREATMENT WHILE A DETERMINATION BY THE EXTERNAL REVIEW AGENT IS PENDING.

S 7. Section 4902 of the public health law is amended by adding two new subdivisions 3 and 4 to read as follows:

3. I. WHEN CONDUCTING A UTILIZATION REVIEW FOR PURPOSES OF DETERMINING HEALTH CARE COVERAGE FOR CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDERS, A UTILIZATION REVIEW AGENT SHALL BE A HEALTH CARE PROVIDER WHO SPECIALIZES IN BEHAVIORAL HEALTH AND WHO HAS EXPERIENCE IN THE DELIVERY OF CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER COURSES OF TREATMENT TO

SUPERVISE AND OVERSEE THE MEDICAL MANAGEMENT DECISIONS RELATING TO SUCH TREATMENT.

II. A UTILIZATION REVIEW AGENT SHALL UTILIZE RECOGNIZED EVIDENCE-BASED AND PEER REVIEWED CLINICAL REVIEW CRITERIA THAT IS APPROPRIATE TO THE AGE OF THE PATIENT AND IS DEEMED APPROPRIATE AND APPROVED FOR SUCH USE BY THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN CONSULTATION WITH THE COMMISSIONER AND THE SUPERINTENDENT OF FINANCIAL SERVICES.

III. THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN CONSULTATION WITH THE COMMISSIONER AND THE SUPERINTENDENT OF FINANCIAL SERVICES SHALL APPROVE A RECOGNIZED EVIDENCE-BASED AND PEER REVIEWED CLINICAL REVIEW CRITERIA, IN ADDITION TO ANY OTHER APPROVED EVIDENCE-BASED AND PEER REVIEWED CLINICAL REVIEW CRITERIA.

4. WHERE AN INSURED'S HEALTHCARE PROVIDER BELIEVES AN IMMEDIATE APPEAL OF AN ADVERSE DETERMINATION FOR TREATMENT RELATING TO CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER IS WARRANTED, ALL INTERNAL APPEALS SHALL BE CONDUCTED ON AN EXPEDITED BASIS AS SET FORTH IN SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS TITLE. WHERE AN ENROLLEE'S HEALTH CARE PROVIDER DETERMINES THAT A DELAY IN PROVIDING CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER TREATMENT WOULD POSE A SERIOUS THREAT TO THE HEALTH OR SAFETY OF THE ENROLLEE, EXTERNAL APPEALS OF UTILIZATION REVIEW DETERMINATIONS WILL BE CONDUCTED ON AN EXPEDITED BASIS AS SET FORTH IN PARAGRAPH (C) OF SUBDIVISION TWO OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS ARTICLE.

S 8. Subdivision 3 of section 4903 of the public health law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

3. A utilization review agent shall make a determination involving continued or extended health care services, additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider, REQUESTS FOR TREATMENT FOR CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the enrollee or the enrollee's designee, which may be satisfied by notice to the enrollee's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, OR REQUESTS FOR TREATMENT FOR CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date. Provided that a request for home health care services and all necessary information is submitted to the utilization review agent prior to discharge from an inpatient hospital admission pursuant to this subdivision, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for home health care services while a determination by the utilization review agent is pending. PROVIDED THAT A REQUEST FOR TREATMENT FOR CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER AND ALL NECESSARY INFORMATION IS SUBMITTED TO THE UTILIZATION REVIEW AGENT PURSUANT TO THIS SUBDIVISION, A UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, COVERAGE FOR CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER TREATMENT SERVICES WHILE A DETERMINATION BY THE UTILIZATION REVIEW AGENT IS PENDING. PROVIDED THAT, UPON ADMIS-

SION TO INPATIENT AND RESIDENTIAL TREATMENT, THE UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, WHEN NOTICE OF ADMISSION FOR PURPOSES OF CARE COORDINATION WAS PROVIDED TO THE UTILIZATION REVIEW AGENT WITHIN TWENTY-FOUR HOURS OF AN ADMISSION; AND A REQUEST FOR TREATMENT FOR SUBSTANCE USE DISORDER AND ALL NECESSARY INFORMATION IS SUBMITTED TO THE UTILIZATION REVIEW AGENT PURSUANT TO THIS SUBDIVISION.

S 9. Subdivision 2 of section 4904 of the public health law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

2. A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving:

(a) continued or extended health care services, procedures or treatments or additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider home health care services following discharge from an inpatient hospital admission pursuant to subdivision three of section forty-nine hundred three of this article; or

(b) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination. Such process shall include mechanisms which facilitate resolution of the appeal including but not limited to the sharing of information from the enrollee's health care provider and the utilization review agent by telephonic means or by facsimile. The utilization review agent shall provide reasonable access to its clinical peer reviewer within one business day of receiving notice of the taking of an expedited appeal. Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process pursuant to section forty-nine hundred fourteen of this article as applicable. PROVIDED THAT THE INSURED OR THE INSURED'S HEALTH CARE PROVIDER NOTIFIES THE UTILIZATION REVIEW AGENT OF ITS INTENT TO FILE AN EXTERNAL APPEAL IMMEDIATELY UPON RECEIPT OF AN APPEAL DETERMINATION AND A REQUEST FOR AN EXPEDITED EXTERNAL APPEAL FOR TREATMENT OF CHEMICAL DEPENDENCE OR SUBSTANCE USE DISORDER AND ALL NECESSARY INFORMATION IS SUBMITTED WITHIN TWENTY-FOUR HOURS OF RECEIPT OF AN APPEAL DETERMINATION, A UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, COVERAGE FOR SUCH TREATMENT WHILE A DETERMINATION BY THE EXTERNAL REVIEW AGENT IS PENDING.

S 10. The superintendent of the department of financial services shall select a random sampling of chemical dependence or substance use disorder treatment coverage determinations and provide an analysis of whether or not such determinations are in compliance with the criteria established in this act and report its finding to the governor, the temporary president of the senate, and speaker of the assembly, the chairs of the senate and assembly insurance committees, and the chairs of the senate and assembly health committees no later than December 31, 2015.

S 11. 1. Within thirty days of the effective date of this act, the commissioner of the office of alcoholism and substance abuse services, superintendent of the department of financial services, and the commissioner of health, shall jointly convene a workgroup to study and make recommendations on improving access to and availability of chemical dependence or substance use disorder treatment services in the state. The workgroup shall be co-chaired by such commissioners and superinten-

dent, and shall also include, but not be limited to, representatives of health care providers, insurers, additional professionals, individuals and families who have been affected by addiction. The workgroup shall include, but not be limited to, a review of the following:

a. Identifying barriers to obtaining necessary chemical dependence or substance use disorder treatment services for across the state;

b. Recommendations for increasing access to and availability of chemical dependence or substance use disorder treatment services in the state, including underserved areas of the state;

c. Identifying best clinical practices for chemical dependence or substance use disorder treatment services;

d. A review of current insurance coverage requirements and recommendations for improving insurance coverage for chemical dependence or substance use disorder and dependency treatment;

e. Recommendations for improving state agency communication and collaboration relating to chemical dependence or substance use disorder treatment services in the state;

f. Resources for affected individuals and families who are having difficulties obtaining necessary chemical dependence or substance use disorder treatment services; and

g. Methods for developing quality standards to measure the performance of chemical dependence or substance use disorder treatment facilities in the state.

2. The workgroup shall submit a report of its findings and recommendations to the governor, the temporary president of the senate, the speaker of the assembly, the chairs of the senate and assembly insurance committees, and the chairs of the senate and assembly health committees no later than December 31, 2015.

S 12. This act shall take effect January 1, 2015; provided, however, that sections one through nine of this act shall apply to all policies and contracts issued, delivered, renewed, modified, altered, or amended after such date.