
OLR Bill Analysis

sSB 877

AN ACT CONCERNING MENTAL HEALTH PARITY.

SUMMARY:

This bill requires large group health insurance policies (those with more than 50 members) to comply with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, P.L. 110-343) and its regulations.

Connecticut already has a mental health parity law that requires individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut to cover the diagnosis and treatment of mental or nervous conditions. The law prohibits a policy from establishing any provisions that place a greater financial burden on an insured for the diagnosis or treatment of mental or nervous conditions than for the diagnosis or treatment of medical, surgical, or other physical health conditions (CGS §§ 38a-488a(b) and 38a-514(b)).

EFFECTIVE DATE: January 1, 2012

BILL APPLICABILITY

The bill applies to large group health insurance policies (including those that are self-insured) delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan.

Under the bill, a fully-insured large group health insurance policy is subject to both federal and state law. But, a self-insured large group policy is subject only to federal law. (Under the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.)

BACKGROUND

State Mental Health Parity Law Definitions

The law defines “mental or nervous conditions” as mental disorders, as it is used in the American Psychiatric Association’s most recent *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR fourth edition, text revision). But, it specifically excludes coverage for (1) mental retardation; (2) learning, motor skills, communication, and caffeine-related disorders; (3) relational problems; and (4) additional conditions not otherwise defined as mental disorders in the DSM.

MHPAEA

Under MHPAEA, a large group health plan that includes mental health benefits is prohibited from imposing financial requirements (e.g., deductibles and co-payments) or treatment limitations (e.g., number of visits or days of coverage) that are more restrictive than the predominant financial requirements and treatment limitations imposed on substantially all medical and surgical benefits. Mental health benefits cannot be subject to any separate cost sharing requirements or treatment limitations that apply only to those benefits. And if a large group health plan includes out-of-network medical and surgical benefits, it must also provide out-of-network mental health benefits.

Federal law also prohibits a large group plan from placing annual or lifetime dollar limits on mental health benefits that are more restrictive than those for medical and surgical benefits offered under the plan. Its provisions apply to substance use disorder benefits in addition to mental health benefits.

MHPAEA acts as a “floor” (i.e., provides minimum requirements upon which a state may build). It applies the Health Insurance Portability and Accountability Act of 1996 (HIPAA) preemption standard, which means that if state mental health parity law provides for more protection than the federal law, it is not preempted.

Related Bills

SB 314, reported favorably by the Insurance and Real Estate

Committee, adds to the list of unfair or deceptive insurance acts the refusal, limitation, or charging of a different rate to an individual diagnosed with a mental or nervous condition.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 11 Nay 7 (02/24/2011)