



House of Representatives

General Assembly

File No. 300

January Session, 2013

House Bill No. 6517

House of Representatives, April 2, 2013

The Committee on Program Review and Investigations reported through REP. MUSHINSKY of the 85th Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE INSURANCE DEPARTMENT'S DUTIES, MENTAL HEALTH PARITY COMPLIANCE CHECKS AND THE EXTERNAL REVIEW APPLICATION PROCESS.

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

1 Section 1. Section 38a-472d of the general statutes is amended by
2 adding subsection (c) as follows (*Effective October 1, 2013*):

3 (NEW) (c) The Insurance Department shall prominently display a
4 link on the department's Internet web site to the Office of the
5 Healthcare Advocate's Internet web site, along with a statement that
6 said office can provide health care consumers or their authorized
7 representatives with free assistance throughout the coverage decision
8 process.

9 Sec. 2. Section 38a-478l of the general statutes is amended by adding
10 subsection (e) as follows (*Effective from passage*):

11 (NEW) (e) Beginning with the consumer report card to be
12 distributed not later than October 15, 2013, the commissioner shall
13 analyze annually the data submitted under subparagraphs (E) and (F)
14 of subdivision (1) of subsection (b) of this section for statistically
15 significant differences in such data among the health care centers and
16 licensed health insurers included in the consumer report card. The
17 commissioner shall investigate any such differences to determine
18 whether further action by the commissioner is warranted.

19 Sec. 3. (*Effective from passage*) (a) (1) Not later than September 1, 2013,
20 the Insurance Commissioner shall submit a report, in accordance with
21 the provisions of section 11-4a of the general statutes, to the joint
22 standing committees of the General Assembly having cognizance of
23 matters relating to insurance and public health on the method the
24 Insurance Department shall use to check for compliance with state and
25 federal mental health parity laws by health insurance companies and
26 other entities under its jurisdiction. In selecting such method, the
27 commissioner shall examine and assess for fitness the methods set
28 forth by the United States Department of Labor and URAC, in addition
29 to any other methods discovered by or brought to the attention of the
30 Insurance Department.

31 (2) As part of the evaluation process, the commissioner shall hold at
32 least one public meeting at which stakeholders, including, but not
33 limited to, relevant state agency personnel, health insurance
34 companies and the general public, are invited to share their input and
35 propose other compliance check methods.

36 (b) The report under subsection (a) of this section shall describe and
37 address the comments shared at the public meeting or meetings,
38 include an assessment of each potential method examined and append
39 written comments and suggestions of the Healthcare Advocate.

40 (c) On or before October 1, 2013, the commissioner shall begin such
41 compliance checks using the compliance check method selected.

42 Sec. 4. Section 38a-478a of the general statutes is repealed and the

43 following is substituted in lieu thereof (*Effective October 1, 2013*):

44 On March first annually, the Insurance Commissioner shall submit a
45 report to the Governor and to the joint standing committees of the
46 General Assembly having cognizance of matters relating to public
47 health and insurance, concerning the commissioner's responsibilities
48 under the provisions of sections 38a-478 to 38a-478u, inclusive, 38a-
49 479aa, 38a-591a to 38a-591h, inclusive, and 38a-993. The report shall
50 include: (1) A summary of the quality assurance plans submitted by
51 managed care organizations pursuant to section 38a-478c along with
52 suggested changes to improve such plans; (2) suggested modifications
53 to the consumer report card developed under the provisions of section
54 38a-478l, as amended by this act; (3) a summary of the commissioner's
55 procedures and activities in conducting market conduct examinations
56 of utilization review companies and preferred provider networks,
57 including, but not limited to: (A) The number of desk and field audits
58 completed during the previous calendar year; (B) a summary of
59 findings of the desk and field audits, including any recommendations
60 made for improvements or modifications; (C) a description of
61 complaints concerning managed care companies, and any preferred
62 provider network that provides services to enrollees on behalf of the
63 managed care organization, including a summary and analysis of any
64 trends or similarities found in the managed care complaints filed by
65 enrollees; (4) a summary of the complaints concerning managed care
66 organizations received by the Insurance Department's Consumer
67 Affairs Division and the commissioner under section 38a-591g,
68 including a summary and analysis of any trends or similarities found
69 in the complaints received; (5) a summary of any violations the
70 commissioner has found against any managed care organization or
71 any preferred provider network that provides services to enrollees on
72 behalf of the managed care organization; [and] (6) a summary of the
73 issues discussed related to health care or managed care organizations
74 at the Insurance Department's quarterly forums throughout the state;
75 and (7) a summary of the method used by the department to check for
76 compliance with state and federal mental health parity laws by health
77 insurance companies and other entities under its jurisdiction, and

78 results of such compliance checks.

79 Sec. 5. (*Effective from passage*) Not later than July 31, 2013, the
 80 Insurance Department shall request the United States Department of
 81 Health and Human Services for a determination as to whether, when
 82 filing a request for an external review or expedited external review as
 83 set forth in section 38a-591g of the general statutes, a covered person or
 84 a covered person's authorized representative, as both terms are
 85 defined in section 38a-591a of the general statutes, may submit (1) a
 86 copy of the notice of final adverse determination, or adverse
 87 determination if such covered person has been deemed to have
 88 exhausted the health carrier's internal grievance process or may file an
 89 external review or expedited external review pursuant to section 38a-
 90 591g of the general statutes, or (2) a copy of the covered person's health
 91 carrier identification card, rather than both. If the United States
 92 Department of Health and Human Services determines a copy of either
 93 such notice or such identification card is sufficient for purposes of
 94 filing an external review or expedited external review, the Insurance
 95 Department shall comply with such determination. If the United States
 96 Department of Health and Human Services determines a copy of both
 97 such notice and such identification card are required, the Insurance
 98 Department shall include in any guide or materials it provides to
 99 consumers concerning external review and expedited external review
 100 processes, a statement that the covered person or the covered person's
 101 authorized representative may request, free of charge, a copy of the
 102 notice of final adverse determination or adverse determination or a
 103 copy of the covered person's health carrier identification card or both
 104 from the health carrier.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2013</i>	38a-472d
Sec. 2	<i>from passage</i>	38a-478l
Sec. 3	<i>from passage</i>	New section
Sec. 4	<i>October 1, 2013</i>	38a-478a
Sec. 5	<i>from passage</i>	New section

PRI 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 14 \$	FY 15 \$
Insurance Department	IF - Cost	Potential	Potential

Municipal Impact: None

Explanation

This bill specifies several requirements concerning the Insurance Department's oversight of compliance with the mental health parity laws. The bill requires the department to perform an evaluation process to select a compliance check method and to begin using the method selected by October 1, 2013. Should the check method selected be more labor intensive than the methods currently utilized by the department, additional administrative costs may result. However, as the method selected cannot be known in advance, the extent of these potential costs is unknown.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis**HB 6517*****AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE INSURANCE DEPARTMENT'S DUTIES, MENTAL HEALTH PARITY COMPLIANCE CHECKS AND THE EXTERNAL REVIEW APPLICATION PROCESS.*****SUMMARY:**

This bill requires the Insurance Department to:

1. review mental health parity compliance check methodologies, hold a public meeting on the methodologies, select and implement a compliance check method, and report to the legislative committees of cognizance on the methodologies and compliance check results;
2. add information on its website about the Office of the Healthcare Advocate (OHA);
3. annually analyze and investigate certain claims denial and utilization review data; and
4. request the U.S. Department of Health and Human Services (HHS) to rule on whether external appeal applicants must provide either an adverse determination notice or an insurance identification card, or both and to act accordingly in response.

EFFECTIVE DATE: Upon passage, except provisions requiring the Insurance Department to (1) annually report on its mental health parity compliance method and (2) add information about OHA on its website, which are effective October 1, 2013.

§§ 3 & 4 — MENTAL HEALTH PARITY COMPLIANCE CHECKS***Method Selection***

The bill requires the insurance commissioner, by September 1, 2013, to report to the Insurance and Public Health committees on the method the Insurance Department will use to check for health insurers' and HMOs' compliance with state and federal mental health parity laws.

In selecting the method to be used, the commissioner must (1) consider and assess methods set forth by the U.S. Department of Labor and URAC (a national accrediting organization) and any other methods brought to the department's attention and (2) hold at least one public meeting at which state agencies, insurers, and the public can share suggestions.

The report must (1) describe and address comments received at the public meeting, (2) assess each potential compliance method examined, and (3) attach written comments and suggestions from the healthcare advocate.

Method Implementation

The bill requires the insurance commissioner, by October 1, 2013, to begin mental health parity compliance checks using the method selected.

Annual Reporting of Results

The law requires the insurance commissioner to annually submit a managed care regulation report to the governor and Insurance and Public Health committees. The bill requires the commissioner to include in the report (1) a summary of the mental health parity compliance check methodology and (2) results of the compliance checks.

§ 1 — INSURANCE DEPARTMENT WEBSITE

The bill requires the Insurance Department to prominently (1) link to OHA's website and (2) post a statement that the office can provide healthcare consumers or their authorized representatives free assistance throughout the coverage decision process.

§ 2 — ANALYZE CONSUMER REPORT CARD DATA

The bill requires the insurance commissioner to annually analyze certain data it receives for the yearly managed care consumer report card for statistically significant differences among insurers and HMOs. The data he must analyze includes (1) claims denial data and (2) utilization review data concerning mental health and chemical dependence services. He must investigate any such differences to determine if further action is necessary.

§ 5 — EXTERNAL REVIEW APPLICATION PROCESS

The bill requires the Insurance Department, by July 31, 2013, to ask HHS, which has established certain external review process requirements, whether it is acceptable to require external review applicants to submit either a final adverse determination notice (e.g., denial letter) or a copy of the insured person's insurance identification card, instead of both.

If HHS responds that either document is sufficient, the department must comply with that determination and require only one, instead of both.

If HHS responds that both documents are required, the department must amend its external review consumer guide or material to include a statement that the insured person or his or her authorized representative can receive, free of charge, a copy of the adverse determination, insurance identification card, or both from the health carrier.

BACKGROUND

Related Bill

sHB 6612, reported favorably by the Insurance and Real Estate Committee, includes similar requirements for (1) mental health parity compliance checks and (2) analyzing consumer report card data.

COMMITTEE ACTION

Program Review and Investigations Committee

Joint Favorable

Yea 10 Nay 0 (03/14/2013)