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## OLR Bill Analysis

**sHB 5373 (as amended by House "A")\***

***AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE REPORTING OF CERTAIN DATA BY MANAGED CARE ORGANIZATIONS AND HEALTH INSURANCE COMPANIES TO THE INSURANCE DEPARTMENT.***

### **SUMMARY:**

Beginning January 1, 2016, this bill expands the information that (1) managed care organizations (MCOs) and health insurers must report to the insurance commissioner by May 1 annually and (2) the insurance commissioner must publish by October 15 annually in the Consumer Report Card on Health Insurance Carriers in Connecticut. The information to be reported and published relates to substance use and mental disorders.

An MCO that fails to file the required information is subject to a fine of \$100 for each day the report is late (CGS § 38a-478b). The bill does not specify a penalty for health insurers who fail to file the required information, thus, the general statutory penalty applies. That penalty allows the commissioner to fine the insurer up to \$15,000 (CGS § 38a-2).

The bill also requires the Connecticut Health Insurance Exchange (HIX) board of directors, by June 30, 2014 and through March 31, 2016, to report quarterly to the Insurance and Real Estate, Public Health, and Program Review and Investigations committees on the progress HIX has made to have the all-payer claims database (APCD) provide the substance use and mental disorder data that the bill requires MCOs and health insurers to report beginning in 2016. The APCD is a database that HIX is developing, to which insurers, HMOs, and other entities must report insurance claims information. The bill allows the HIX board to combine this quarterly report with other quarterly reports the law already requires.

\*House Amendment "A" eliminates a provision that allows an MCO to ask the insurance commissioner to consider certain information confidential and not subject to disclosure under the Freedom of Information Act. It limits the (1) types of health insurers that must report substance use and mental disorder information to the commissioner and (2) information the commissioner must publish in his annual report card. It also (1) changes the effective date for the MCO and health insurer reporting requirements from October 1, 2014 to January 1, 2016, (2) adds the HIX quarterly reporting requirement, and (3) makes technical changes.

EFFECTIVE DATE: Upon passage for the HIX quarterly reporting requirement, and January 1, 2016 for the remaining provisions.

### **MANAGED CARE ORGANIZATION**

By law, an "MCO" is an insurer, health care center (i.e., HMO), hospital or medical service corporation, or other organization delivering, issuing, renewing, amending, or continuing an individual or group health managed care plan in the state. A "managed care plan" is a product an MCO offers that finances or delivers health care services to plan enrollees through a network of participating providers.

The bill requires MCOs to report to the insurance commissioner by May 1 annually, by county, the:

1. estimated prevalence of substance use disorders among covered children (under age 16), young adults (age 16 to 25), and adults (age 26 and older);
2. number and percentage of covered children, young adults, and adults who received covered treatment for a substance use disorder, by level of care provided (e.g., inpatient, outpatient, residential care, and partial hospitalization);
3. median length of covered treatment provided to covered children, young adults, and adults for a substance use disorder, by level of care provided;

4. per-member, per-month claim expenses for covered children, young adults, and adults who received covered treatment for substance use disorders; and
5. number of in-network health care providers who provide substance use disorder treatment, by level of care, and the percentage of such providers who are accepting new clients under the MCO's plans.

The bill requires the commissioner to include the above information in his annual Consumer Report Card on Health Insurance Carriers in Connecticut.

The bill also requires MCOs to report to the commissioner by May 1 annually:

1. the number, by licensure type, of health care providers who treat substance use disorders, co-occurring disorders, and mental disorders, who, in the preceding calendar year (a) applied for in-network status, and the percentage who were accepted, and (b) no longer participated in the network;
2. the number, by level of care provided, of health care facilities that treat substance use disorders, co-occurring disorders, and mental disorders, that, in the preceding calendar year (a) applied for in-network status, and the percentage that were accepted, and (b) no longer participated in the network; and
3. factors that may negatively affect covered enrollees' access to substance use disorder treatment, including screening procedures, the supply of health care providers and their capacity limitations, and provider reimbursement rates, and plans and ongoing or completed activities to address those factors.

## **HEALTH INSURER**

The bill requires each health insurer that provides coverage for the diagnosis and treatment of mental or nervous conditions under state

law to report to the insurance commissioner, by May 1 annually, data on benefit requests, utilization review of benefit requests, adverse determinations, final adverse determinations, and external appeals, for the treatment of substance use disorders, co-occurring disorders, and mental disorders. The information must be grouped by (1) the level of care, (2) category, and (3) age group (i.e., children, young adult, and adults).

The bill requires the commissioner to include this information in his annual Consumer Report Card on Health Insurance Carriers in Connecticut for the 15 largest licensed health insurers.

**COMMITTEE ACTION**

Program Review and Investigations Committee

Joint Favorable Substitute

Yea 11 Nay 0 (03/13/2014)

Insurance and Real Estate Committee

Joint Favorable

Yea 15 Nay 2 (04/08/2014)