

OFFICE OF LEGISLATIVE RESEARCH
PUBLIC ACT SUMMARY



PA 14-58—sHB 5373 (VETOED)

*Program Review and Investigations Committee
Insurance and Real Estate Committee*

**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 act adds certain data on substance abuse and mental disorders to 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.

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 act does not contain a penalty for health insurers who fail to file, but existing law allows the commissioner to fine the insurer up to \$15,000 for violations of the Insurance title (CGS § 38a-2).

The act 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 act 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 act allows the HIX board to combine this quarterly report with other quarterly reports the law already requires. **EFFECTIVE DATE:** Upon passage for the HIX quarterly reporting requirement and January 1, 2016 for the remaining provisions.

MANAGED CARE ORGANIZATIONS

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

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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 accepting new clients under the MCO's plans.

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

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

1. number, by licensure type, of health care providers who treat substance use disorders, co-occurring disorders, and mental disorders and who, in the preceding calendar year, (a) applied for in-network status and the percentage accepted and (b) no longer participated in the network;
2. number, by level of care provided, of health care facilities that treat substance use disorders, co-occurring disorders, and mental disorders and that, in the preceding calendar year, (a) applied for in-network status and the percentage accepted and (b) no longer participated in the network; and
3. (a) 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 (b) plans and ongoing or completed activities to address those factors.

HEALTH INSURERS

The act requires each health insurer that provides coverage for the diagnosis and treatment of mental or nervous conditions under state law to report certain data to the insurance commissioner by May 1 annually. That data includes 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 adults, and adults).

The act 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. Prior law instead required him to include information on the percentage of enrollees receiving mental health services, utilization of mental health and chemical dependence services, inpatient and outpatient admissions, discharge rates, and average lengths of stay.

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