OLR Bill Analysis

sSB 384

AN ACT CONCERNING MENTAL HEALTH PARITY, DATA REPORTED BY MANAGED CARE ORGANIZATIONS AND THE ALL-PAYER CLAIMS DATABASE.

SUMMARY

This bill requires certain health insurance policies to cover, at an annual physical, screenings for mental or nervous conditions. It also:

1. expands reporting requirements for the insurance commissioner, managed care organizations, health carriers, health insurers, and the all-payers claims database and

2. changes the data that must be included in the Consumer Report Card on Health Insurance Carriers in Connecticut and, in doing so, changes the data the insurance commissioner may investigate for discrepancies.

Additionally, it specifies that (1) health carriers must comply with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) (P.L. 110-343) and (2) the federal act prevails in any conflict with state law or regulation and allows the commissioner to adopt implementing regulations.

The bill also makes minor, technical, and conforming changes.

EFFECTIVE DATE: January 1, 2019

§§ 8 & 9 — SCREENING COVERAGE

The bill adds screening for mental or nervous conditions during an annual physical exam to the specified services related to mental and nervous conditions that certain health insurance policies must cover. The requirement applies to individual and group health insurance policies issued, delivered, renewed, amended, or continued in

Connecticut that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, or (4) hospital or medical services, including those provided through an HMO.

§§ 1, 3 & 5 — HEALTH CARRIER REPORT TO THE COMMISSIONER

Under the bill, health carriers must submit to the insurance commissioner, annually by March 1, a report covering the preceding calendar year that includes information the bill specifies in a form she prescribes. The commissioner may require that a carrier, in making the report, disclose proprietary or competitive information. She must maintain this information's confidentiality and is prohibited from disclosing it to any person unless necessary to carry out the bill's provisions. The bill allows the commissioner to accept a report submitted electronically.

The report, excluding any confidential or proprietary information, must be posted on the department's website.

The bill requires the commissioner to adopt implementing regulations.

Report Content

Mental and Physical Health and Substance Abuse Benefits. The report must include, for mental health, physical health, and substance abuse benefits, the (1) ratio of claims requiring prior authorization to total claims received, (2) ratio of denied claims to total claims received, (3) reasons the carrier denied any claim, and (4) amount of reimbursement paid to the benefit provider (presumably, this refers to the total reimbursement paid to all providers). The report must disclose such information for (1) in-network and out-of-network inpatient and outpatient services and (2) pharmaceutical services and products.

The report must also describe any criteria the carrier uses to determine whether a particular mental health, physical health, or substance abuse service is medically necessary and therefore covered, including (1) all processes and methods used to develop the criteria,

and (2) certification that an independent provider, actively practicing in Connecticut and in the relevant specialty area, determined that the criteria were consistent with generally accepted medical standards at the time they were adopted.

Under the bill, a medically necessary health care service is one that a provider actively practicing in Connecticut, in the relevant practice area, would provide to prevent, evaluate, diagnose, or treat an illness, injury, or disease or its symptoms. Medically necessary services must also be (1) in accordance with generally accepted medical practice standards; (2) clinically appropriate in type, frequency, extent, site, and duration for the patient's illness, injury, or disease; (3) not primarily for the patient's or provider's convenience; and (4) not more costly than other therapeutically or diagnostically equivalent services that are at least as likely to produce equivalent therapeutic or diagnostic results.

Nonquantitative Treatment Limitations. The report must also describe each nonquantitative treatment limitation used during the preceding calendar year, including:

1. whether the carrier used such a limitation with respect to any mental health, physical health, or substance abuse benefits, or any combination thereof;

2. all processes and methods used to develop the limitation;

3. all factors the carrier considered and did or did not use in deciding whether to apply the limitation to a particular covered benefit; and

4. a certification that it did not apply the limitations more stringently to claims for mental health and substance abuse benefits than it did to claims for physical health benefits.

Under the bill, a nonquantitative treatment limitation is an evidentiary standard, process, strategy, or other non-numerical factor that denies or limits a covered benefit (e.g., step therapy or pre-

authorization requirements).

Additional Report Requirements. The report must also include (1) a certification from the carrier that, after a review of its internal standards, practices, and procedures, it complies with MHPAEA, the federal Affordable Care Act, and state mental health parity laws and (2) any other information the commissioner requires.

§§ 1, 4, 5 & 7 — INSURANCE COMMISSIONER REPORTING REQUIREMENTS

Report to the Insurance and Real Estate Committee (§ 4)

The bill requires the commissioner to begin annually reporting to the Insurance and Real Estate Committee by June 1, 2019. The report must describe, for the preceding year, the department's:

1. processes and methods used to ensure compliance with MHPAEA and the results;

2. processes and methods used to ensure compliance with state mental health parity laws and the results;

3. efforts to educate health carriers regarding their responsibility to comply with MHPAEA and any regulations adopted under the bill, including regulations adopted to implement the reporting requirement described above;

4. public education efforts regarding carriers' compliance with MHPAEA and any adopted regulations; and

5. actions taken to enforce the health carriers' compliance with MHPAEA and any adopted regulations.

The bill requires the (1) report to be in plain language and posted on the departments website and (2) commissioner to adopt implementing regulations.

Under the bill, the Insurance and Real Estate Committee may require the commissioner to attend an informational hearing and be available to answer questions regarding the report.

Consumer Report Card (§ 7)

The bill makes changes to the consumer report card, which is an annual report issued by the commissioner that contains certain comparative information, including each insurer's state and federal medical loss ratio (i.e., the ratio of incurred claims to earned premiums).

The bill removes requirements that the report card provide certain data related to mental health services, including (1) the percent of enrollees receiving mental health services, (2) the utilization of mental health and chemical dependence services, (3) inpatient and outpatient admissions, (4) discharge rates, and (5) average stay lengths. The bill instead requires the report card to contain the prevalence, by county, of substance use disorders in children, young adults, and adults covered by managed care organizations, as reported by the organizations (see below).

By law, the insurance commissioner must analyze certain information she receives for the consumer report card to determine the accuracy of, trends in, and statistically significant difference among such information for the health care centers and insurers in Connecticut. She may also investigate such differences to determine if further action is warranted. By adding mental health services data to the report card, the bill also requires the commissioner to analyze that data and permits her to investigate any discrepancies.

Mental and Nervous Condition Reporting

The bill also requires, by May 1 annually, each health insurer providing coverage for mental or nervous conditions to submit to the commissioner data for:

1. benefit requests, utilization reviews, adverse determinations, and final adverse determinations for treating acute and routine substance use disorders, co-occurring disorders, and mental disorders and

2. external appeals for treating substance use, co-occurring, and

mental disorders.

The data must be grouped by levels of care (including inpatient, outpatient, residential care, and partial hospitalization), category (substance use, co-occurring, and mental disorders) and age (children, young adults, and adults).

By law, the commissioner must analyze such data for accuracy and statistically significant differences between health care centers and may investigate any discrepancies she finds.

§ 6 — MANAGED CARE ORGANIZATIONS

The bill requires managed care organizations to report certain substance use disorder treatment information to the commissioner annually by May 1.

Substance Use Report

Under the bill, managed care organizations must report on the prevalence of substance use disorders in covered children (i.e., under 16 years old), young adults (i.e., age 16 through 25), and adults (i.e., age 26 and older), by county. The report must include the:

1. number and percent of covered children, young adults, and adults who received covered substance use disorder treatment, by level of care provided;

2. median length of a covered treatment for such individuals, by level of care provided;

3. per member per month claim expenses for such individuals who received covered substance use disorder treatments; and

4. number of in-network health care providers providing substance use disorder treatment, by level of care, and the percent accepting new in-network clients.

Presumably, the report contains such information for the preceding year.

Substance Use Disorder Provider and Health Care Facility Reports

Under the bill, managed care organizations must also report on the number of (1) health care providers treating substance use disorders, co-occurring disorders, and mental disorders by license type, and (2) health care facilities treating such disorders, by level of care provided.

The reports must include only those providers or facilities who, since the last report, (1) applied for in-network status, and the percentage accepted and (2) no longer participate in the network. (The bill does not appear to require the number of current providers or facilities; only the number that entered or left the network.)

Substance Use Disorder Treatment Obstacles Report

Managed care organizations must also identify and explain factors that may be negatively impacting a covered individual's access to substance use, co-occurring, or mental disorder treatment, including (1) screening procedures, (2) statewide supply of certain providers and their capacity, and (3) provider reimbursement rates. The report must include plans and ongoing or completed activities to address these factors.

Office of Health Strategy (§ 10)

The bill requires the Office of Health Strategy to report, beginning June 30, 2019 and quarterly thereafter, to the Public Health and Insurance and Real Estate committees on the office's activities and progress related to requiring the all-payer claims database to provide the new data the bill requires managed care organizations to annually report to the commissioner.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 21 Nay 0 (03/20/2018)