OLR Bill Analysis

sSB 384 (File 338, as amended by Senate "A")*

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 expands:

1. reporting requirements for the insurance commissioner, health carriers, and the Office of Health Strategy (OHS) and

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

Additionally, the bill 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. It allows the commissioner to adopt regulations to implement these provisions.

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

*Senate Amendment "A" (1) eliminates a provision requiring managed care organizations to annually report certain substance use disorder treatment information to the commissioner; (2) eliminates a provision requiring the insurance commissioner to report on mental health parity enforcement and education; (3) narrows the information carriers must submit on nonquantitative treatment limitations; (4) allows, rather than requires, the insurance commissioner to adopt implementing regulations; (5) allows the Public Health Committee, in

addition to the Insurance and Real Estate Committee, to require the insurance commissioner to hold a hearing on the health carrier report's contents; and (6) makes additional minor changes.

EFFECTIVE DATE: January 1, 2019

§§ 6 & 7 — 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 & 4 — HEALTH CARRIER REPORT TO THE COMMISSIONER

Under the bill, health carriers must submit to the insurance commissioner and the Insurance and Real Estate Committee, annually by March 1, a report covering the preceding calendar year that includes certain specified information about mental and physical health and substance abuse benefit claims (described below). The commissioner must prescribe the report's format and 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 an electronically submitted report.

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

The bill allows the commissioner to adopt implementing regulations.

Under the bill, the Insurance and Real Estate and Public Health committees, may, after receiving the report, require the commissioner

to attend an informational hearing and be available to answer questions regarding the report. (However, the bill does not require the commissioner to submit the report to the Public Health Committee.)

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.

Nonquantitative Treatment Limitations. The report must also describe each nonquantitative treatment limitation used during the preceding calendar year, including whether the carrier used such a limitation with respect to any mental health, physical health, or substance abuse benefits, or any combination thereof.

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.

§ 5 — CONSUMER REPORT CARD

Mental and Nervous Condition Reporting

The bill 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).

Consumer Report Card

The bill expands the information the insurance commissioner must report in the consumer report card to include the mental and nervous condition reporting data described above. By law, the consumer report card is an annual report issued by the commissioner that contains certain comparative information on HMOs and the 15 largest health insurers that use provider networks in the state.

The bill correspondingly eliminates a requirement 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.

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 HMOs 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.

(The bill also requires the report card to contain certain information by reference to an incorrect citation. As such, this provision appears to have no legal effect.)

§ 8 — OFFICE OF HEALTH STRATEGY

The bill requires OHS to report each quarter, beginning by June 30, 2019, and until and including March 31, 2021, 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 health insurers to annually report to the commissioner.

(The bill also requires OHS to report certain information by reference to an incorrect citation. As a result, this provision appears to have no legal effect).

COMMITTEE ACTION

Insurance and Real Estate Committee

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