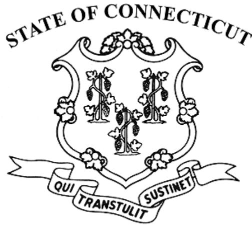

Senate

General Assembly

File No. 338

February Session, 2018

Substitute Senate Bill No. 384

Senate, April 9, 2018

The Committee on Insurance and Real Estate reported through SEN. LARSON of the 3rd Dist. and SEN. KELLY of the 21st Dist., Chairpersons of the Committee on the part of the Senate, that the substitute bill ought to pass.

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

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

1 Section 1. (NEW) (*Effective January 1, 2019*) For the purposes of this
2 section and sections 2 to 5, inclusive, of this act:

3 (1) "Commissioner" means the Insurance Commissioner.

4 (2) "Covered benefits" means any health care services to which an
5 enrollee or insured is entitled under the terms of any individual or
6 group health insurance policy.

7 (3) "Department" means the Insurance Department.

8 (4) "Generally accepted standards of medical practice" has the same
9 meaning as provided in section 38a-482a of the general statutes.

10 (5) "Group health insurance policy" means any group health
11 insurance policy providing coverage of the type specified in
12 subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 of the
13 general statutes.

14 (6) "Health care provider" or "provider" means a person licensed to
15 provide health care services under chapters 370 to 373, inclusive, 375 to
16 383c, inclusive, 384a to 384c, inclusive, and 400j of the general statutes.

17 (7) "Health care services" or "services" means services for the
18 diagnosis, prevention, treatment, cure or relief of a mental or nervous
19 condition, physical health condition or substance use disorder.

20 (8) "Health carrier" or "carrier" means an insurer, fraternal benefit
21 society, health care center, hospital service corporation, managed care
22 organization, medical service corporation or other entity that delivers,
23 issues for delivery, renews, amends or continues in this state any
24 individual or group health insurance policy.

25 (9) "Individual health insurance policy" means any individual health
26 insurance policy providing coverage of the type specified in
27 subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 of the
28 general statutes.

29 (10) "Medically necessary" means health care services that a
30 provider, actively practicing in this state in the relevant practice area
31 and exercising prudent clinical judgment, would provide to a patient
32 for the purpose of preventing, evaluating, diagnosing or treating an
33 illness, injury, disease or its symptoms, and that are (A) in accordance
34 with generally accepted standards of medical practice, (B) clinically
35 appropriate, in terms of type, frequency, extent, site and duration and
36 considered effective for the patient's illness, injury or disease, and (C)
37 not primarily for the convenience of the patient or provider and not
38 more costly than an alternative service or sequence of services at least
39 as likely to produce equivalent therapeutic or diagnostic results as to
40 the diagnosis or treatment of that patient's illness, injury or disease.

41 (11) "Mental health benefits" means covered benefits for any health
42 care services rendered to prevent, evaluate, diagnose or treat one or
43 more mental or nervous conditions.

44 (12) "Mental Health Parity and Addiction Equity Act" means the
45 Paul Wellstone and Pete Domenici Mental Health Parity and
46 Addiction Equity Act of 2008, P.L. 110-343, as amended from time to
47 time, and regulations adopted thereunder.

48 (13) "Mental or nervous condition" has the same meaning as
49 provided in section 38a-488a of the general statutes, as amended by
50 this act.

51 (14) "Nonquantitative treatment limitation" means any evidentiary
52 standard, process, strategy or other nonnumerical factor that has the
53 effect of denying or limiting a covered benefit.

54 (15) "Physical health benefits" means covered benefits for any health
55 care services rendered to prevent, evaluate, diagnose or treat one or
56 more physical health conditions.

57 (16) "Physical health condition" means any illness or dysfunction of,
58 or injury to, the human body. "Physical health condition" does not
59 include any (A) mental or nervous condition, or (B) substance use
60 disorder.

61 (17) "Substance abuse benefits" means covered benefits for any
62 health care services rendered to prevent, evaluate, diagnose or treat
63 one or more substance use disorders.

64 (18) "Substance use disorder" means any moderate or severe alcohol
65 or substance use disorder, as defined in the most recent edition of the
66 American Psychiatric Association's "Diagnostic and Statistical Manual
67 of Mental Disorders."

68 Sec. 2. (NEW) (*Effective January 1, 2019*) Each health carrier shall
69 comply with the Mental Health Parity and Addiction Equity Act in
70 addition to the requirements of state laws and regulations. If there is a

71 conflict, the Mental Health Parity and Addiction Equity Act shall
72 govern.

73 Sec. 3. (NEW) (*Effective January 1, 2019*) (a) On or before March first
74 of each year, each health carrier shall submit to the commissioner a
75 report covering the preceding calendar year. The report shall be on a
76 form prescribed by the commissioner and shall include:

77 (1) (A) With respect to claims for mental health benefits the carrier
78 received, and for each category of services set forth in subparagraph
79 (D) of this subdivision, (i) the ratio of the total number of claims for
80 which the carrier required prior authorization to the total number of
81 claims the carrier received, (ii) the ratio of the total number of claims
82 the carrier denied to the total number of claims the carrier received,
83 (iii) the reason the carrier denied any claim, and (iv) the amount of the
84 reimbursement that the carrier paid to the provider who provided
85 such benefits;

86 (B) With respect to claims for physical health benefits the carrier
87 received, and for each category of services set forth in subparagraph
88 (D) of this subdivision, (i) the ratio of the total number of claims for
89 which the carrier required prior authorization to the total number of
90 claims the carrier received, (ii) the ratio of the total number of claims
91 the carrier denied to the total number of claims the carrier received,
92 (iii) the reason the carrier denied any claim, and (iv) the amount of the
93 reimbursement that the carrier paid to the provider who provided
94 such benefits;

95 (C) With respect to claims for substance abuse benefits the carrier
96 received, and for each category of services set forth in subparagraph
97 (D) of this subdivision, (i) the ratio of the total number of claims for
98 which the carrier required prior authorization to the total number of
99 claims the carrier received, (ii) the ratio of the total number of claims
100 the carrier denied to the total number of claims the carrier received,
101 (iii) the reason the carrier denied any claim, and (iv) the amount of the
102 reimbursement that the carrier paid to the provider who provided
103 such benefits; and

104 (D) Each carrier shall disclose information under subparagraphs (A)
105 to (C), inclusive, of this subdivision for (i) in-network services
106 provided on an inpatient basis, (ii) in-network services provided on an
107 outpatient basis, (iii) out-of-network services provided on an inpatient
108 basis, (iv) out-of-network services provided on an outpatient basis, (v)
109 emergency medical services, and (vi) pharmaceutical services and
110 products;

111 (2) With respect to any criteria the carrier used to determine
112 whether a particular service was medically necessary and therefore
113 covered as a mental health benefit, physical health benefit or substance
114 abuse benefit, a statement (A) describing the criteria, (B) describing all
115 processes and methods used to develop the criteria, and (C) with
116 respect to any criteria developed by the carrier, a statement by the
117 carrier certifying that an independent provider, actively practicing in
118 this state and in the relevant specialty area, determined that the criteria
119 were, at the time the carrier adopted the criteria, consistent with
120 generally accepted standards of medical practice;

121 (3) With respect to each nonquantitative treatment limitation the
122 carrier used during the relevant calendar year, a statement (A)
123 describing the nonquantitative treatment limitation, (B) disclosing
124 whether the carrier used the nonquantitative treatment limitation with
125 respect to claims for mental health benefits, physical health benefits,
126 substance abuse benefits or any combination thereof, (C) describing all
127 processes and methods used to develop the nonquantitative treatment
128 limitation, (D) describing all factors the carrier considered and used in
129 determining whether it would apply the nonquantitative treatment
130 limitation to a particular covered benefit, (E) describing all factors the
131 carrier considered but did not use in determining whether it would
132 apply the nonquantitative treatment limitation to a particular covered
133 benefit, (F) by the carrier certifying that it did not apply the
134 nonquantitative treatment limitation more stringently to claims for
135 mental health benefits and substance abuse benefits than physical
136 health benefits, and (G) describing the processes and methods the
137 carrier used to ensure that it did not apply the nonquantitative

138 treatment limitation more stringently to claims for mental health
139 benefits or substance abuse benefits than claims for physical health
140 benefits;

141 (4) A statement from the carrier certifying, after review of its
142 internal standards, practices and procedures, that it is in compliance
143 with (A) sections 38a-488a and 38a-514 of the general statutes, as
144 amended by this act, as applicable, (B) the Mental Health Parity and
145 Addiction Equity Act, and (C) the Patient Protection and Affordable
146 Care Act, P.L. 111-148, as amended from time to time, and regulations
147 adopted thereunder; and

148 (5) Any other information as the commissioner may require.

149 (b) The commissioner may require that any carrier, in making a
150 report under subsection (a) of this section, disclose information
151 deemed by the carrier to be of a proprietary or competitive nature,
152 provided the commissioner shall maintain the information as
153 confidential and shall not disclose the information to any person
154 except to the extent necessary to carry out the purposes of sections 1 to
155 5, inclusive, of this act. For the purposes of sections 1 to 5, inclusive, of
156 this act, information is of a proprietary or competitive nature if
157 revealing the information would cause the carrier's competitors to
158 obtain valuable business information.

159 (c) The information required under subsection (a) of this section
160 shall be posted on the department's Internet web site, except that no
161 information that is of a proprietary or competitive nature within the
162 meaning of subsection (b) of this section shall be posted on the
163 department's Internet web site.

164 (d) The commissioner may accept any part of the filing required
165 under subsection (a) of this section in electronic form.

166 Sec. 4. (NEW) (*Effective January 1, 2019*) (a) Not later than June 1,
167 2019, and annually thereafter, the commissioner shall submit a report,
168 in accordance with section 11-4a of the general statutes, to the joint

169 standing committee of the General Assembly having cognizance of
170 matters relating to insurance. The report shall include the following
171 information and statements for the preceding calendar year:

172 (1) A statement describing all processes and methods the
173 department used to ensure that each health carrier complied with the
174 Mental Health Parity and Addiction Equity Act and the results of such
175 processes and methods;

176 (2) A statement describing all processes and methods the
177 department used to ensure that each carrier complied with sections
178 38a-488a and 38a-514 of the general statutes, as amended by this act,
179 and the results of such processes and methods;

180 (3) A statement describing any efforts the department made to
181 educate carriers concerning compliance with section 2 of this act and
182 any regulations adopted under section 5 of this act;

183 (4) A statement describing any efforts the department made to
184 educate the public concerning the requirement that carriers comply
185 with section 2 of this act and any regulations adopted under section 5
186 of this act; and

187 (5) A statement describing any actions the department has taken to
188 enforce section 2 of this act or any regulations adopted under section 5
189 of this act.

190 (b) The report required under subsection (a) of this section shall be
191 in plain language.

192 (c) The report required under subsection (a) of this section shall be
193 posted on the department's Internet web site.

194 (d) The joint standing committee of the General Assembly having
195 cognizance of matters relating to insurance may require the
196 commissioner to attend an informational hearing following its receipt
197 of a report submitted under subsection (a) of this section. The
198 commissioner shall attend and be available for questions from the

199 members of the committee at the hearing.

200 Sec. 5. (NEW) (*Effective January 1, 2019*) The commissioner shall
201 adopt regulations, in accordance with chapter 54 of the general
202 statutes, to implement the provisions of sections 1 to 4, inclusive, of
203 this act.

204 Sec. 6. Section 38a-478c of the general statutes is repealed and the
205 following is substituted in lieu thereof (*Effective January 1, 2019*):

206 (a) On or before May first of each year, each managed care
207 organization shall submit to the commissioner:

208 (1) A report on its quality assurance plan that includes, but is not
209 limited to, information on complaints related to providers and quality
210 of care, on decisions related to patient requests for coverage and on
211 prior authorization statistics. Statistical information shall be submitted
212 in a manner permitting comparison across plans and shall include, but
213 not be limited to: (A) The ratio of the number of complaints received to
214 the number of enrollees; (B) a summary of the complaints received
215 related to providers and delivery of care or services and the action
216 taken on the complaint; (C) the ratio of the number of prior
217 authorizations denied to the number of prior authorizations requested;
218 (D) the number of utilization review determinations made by or on
219 behalf of a managed care organization not to certify an admission,
220 service, procedure or extension of stay, and the denials upheld and
221 reversed on appeal within the managed care organization's utilization
222 review procedure; (E) the percentage of those employers or groups
223 that renew their contracts within the previous twelve months; and (F)
224 notwithstanding the provisions of this subsection, on or before July
225 first of each year, all data required by the National Committee for
226 Quality Assurance for its Health Plan Employer Data and Information
227 Set. If an organization does not provide information for the National
228 Committee for Quality Assurance for its Health Plan Employer Data
229 and Information Set, then it shall provide such other equivalent data as
230 the commissioner may require by regulations adopted in accordance
231 with the provisions of chapter 54. The commissioner shall find that the

232 requirements of this subdivision have been met if the managed care
233 plan has received a one-year or higher level of accreditation by the
234 National Committee for Quality Assurance and has submitted the
235 Health Plan Employee Data Information Set data required by
236 subparagraph (F) of this subdivision;

237 (2) A model contract that contains the provisions currently in force
238 in contracts between the managed care organization and preferred
239 provider networks in this state, and the managed care organization
240 and participating providers in this state and, upon the commissioner's
241 request, a copy of any individual contracts between such parties,
242 provided the contract may withhold or redact proprietary fee schedule
243 information;

244 (3) A written statement of the types of financial arrangements or
245 contractual provisions that the managed care organization has with
246 hospitals, utilization review companies, physicians, preferred provider
247 networks and any other health care providers including, but not
248 limited to, compensation based on a fee-for-service arrangement, a
249 risk-sharing arrangement or a capitated risk arrangement;

250 (4) Such information as the commissioner deems necessary to
251 complete the consumer report card required pursuant to section 38a-
252 478*l*, as amended by this act. Such information may include, but need
253 not be limited to: (A) The organization's characteristics, including its
254 model, its profit or nonprofit status, its address and telephone number,
255 the length of time it has been licensed in this and any other state, its
256 number of enrollees and whether it has received any national or
257 regional accreditation; (B) a summary of the information required by
258 subdivision (3) of this subsection, including any change in a plan's
259 rates over the prior three years, its state medical loss ratio and its
260 federal medical loss ratio, as both terms are defined in section 38a-478*l*,
261 as amended by this act, how it compensates health care providers and
262 its premium level; (C) a description of services, the number of primary
263 care physicians and specialists, the number and nature of participating
264 preferred provider networks and the distribution and number of

265 hospitals, by county; (D) utilization review information, including the
266 name or source of any established medical protocols and the utilization
267 review standards; (E) medical management information, including the
268 provider-to-patient ratio by primary care provider and specialty care
269 provider, the percentage of primary and specialty care providers who
270 are board certified, and how the medical protocols incorporate input as
271 required in section 38a-478e; (F) the quality assurance information
272 required to be submitted under the provisions of subdivision (1) of
273 subsection (a) of this section; (G) the status of the organization's
274 compliance with the reporting requirements of this section; (H)
275 whether the organization markets to individuals and Medicare
276 recipients; (I) the number of hospital days per thousand enrollees; and
277 (J) the average length of hospital stays for specific procedures, as may
278 be requested by the commissioner;

279 (5) A summary of the procedures used by managed care
280 organizations to credential providers; **[**and**]**

281 (6) A report on claims denial data for lives covered in the state for
282 the prior calendar year, in a format prescribed by the commissioner,
283 that includes: (A) The total number of claims received; (B) the total
284 number of claims denied; (C) the total number of denials that were
285 appealed; (D) the total number of denials that were reversed upon
286 appeal; (E) (i) the reasons for the denials, including, but not limited to,
287 "not a covered benefit", "not medically necessary" and "not an eligible
288 enrollee", (ii) the total number of times each reason was used, and (iii)
289 the percentage of the total number of denials each reason was used;
290 and (F) other information the commissioner deems necessary; **[**.**]**

291 (7) A report, by county, on: (A) The estimated prevalence of
292 substance use disorders, as described in section 17a-458, among
293 covered children, young adults and adults; (B) the number and
294 percentage of covered children, young adults and adults who received
295 covered treatment of a substance use disorder by level of care
296 provided; (C) the median length of a covered treatment provided to
297 covered children, young adults and adults for a substance use disorder

298 by level of care provided; (D) the per member, per month claim
299 expenses for covered children, young adults and adults who received
300 covered treatment of substance use disorders; and (E) the number of
301 in-network health care providers who provide treatment of substance
302 use disorders, by level of care, and the percentage of such providers
303 who are accepting new clients under such managed care organization's
304 plan or plans. For the purposes of this subdivision, "children" means
305 individuals less than sixteen years of age, "young adults" means
306 individuals sixteen years of age or older but less than twenty-six years
307 of age and "adults" means individuals twenty-six years of age or older;

308 (8) A state-wide report on the number, by licensure type, of health
309 care providers who provide treatment of substance use disorders, co-
310 occurring disorders and mental disorders, who, in the calendar year
311 immediately preceding for the initial report and since the last report
312 submitted to the commissioner for subsequent reports, (A) have
313 applied for in-network status and the percentage of those who were
314 accepted for such status, and (B) no longer participate in the network;

315 (9) A state-wide report on the number, by level of care provided, of
316 health care facilities that provide treatment of substance use disorders,
317 co-occurring disorders and mental disorders that, in the calendar year
318 immediately preceding for the initial report and since the last report
319 submitted to the commissioner for subsequent reports, (A) have
320 applied for in-network status and the percentage of those that were
321 accepted for such status, and (B) no longer participate in the network;

322 (10) A report identifying and explaining factors that may be
323 negatively impacting covered individuals' access to treatment of
324 substance use disorders, co-occurring disorders and mental disorders
325 which may include, but need not be limited to, screening procedures,
326 the state-wide supply of certain categories of health care providers,
327 health care provider capacity limitations and provider reimbursement
328 rates; and

329 (11) Plans and ongoing or completed activities to address the factors
330 identified in subdivision (10) of this subsection.

331 (b) The information required pursuant to subdivisions (1) to (6),
332 inclusive, of subsection (a) of this section shall be consistent with the
333 data required by the National Committee for Quality Assurance
334 (NCQA) for its Health Plan Employer Data and Information Set
335 (HEDIS).

336 (c) The commissioner may accept electronic filing for any of the
337 requirements under this section.

338 (d) No managed care organization shall be liable for a claim arising
339 out of the submission of any information concerning complaints
340 concerning providers, provided the managed care organization
341 submitted the information in good faith.

342 (e) The information required under subdivision (6) of subsection (a)
343 of this section shall be posted on the Insurance Department's Internet
344 web site.

345 Sec. 7. Section 38a-478*l* of the general statutes is repealed and the
346 following is substituted in lieu thereof (*Effective January 1, 2019*):

347 (a) Not later than October fifteenth of each year, the Insurance
348 Commissioner, after consultation with the Commissioner of Public
349 Health, shall develop and distribute a consumer report card on all
350 managed care organizations. The commissioner shall develop the
351 consumer report card in a manner permitting consumer comparison
352 across organizations.

353 (b) (1) The consumer report card shall be known as the "Consumer
354 Report Card on Health Insurance Carriers in Connecticut" and shall
355 include (A) all health care centers licensed pursuant to chapter 698a,
356 (B) the fifteen largest licensed health insurers that use provider
357 networks and that are not included in subparagraph (A) of this
358 subdivision, (C) the state medical loss ratio of each such health care
359 center or licensed health insurer, (D) the federal medical loss ratio of
360 each such health care center or licensed health insurer, (E) the
361 information required under [subdivision] subdivisions (6) and (7) of

362 subsection (a) of section 38a-478c, as amended by this act, and (F) the
363 information [concerning mental health services, as specified in]
364 required under subsection (c) of this section for each such licensed
365 health insurer. The insurers selected pursuant to subparagraph (B) of
366 this subdivision shall be selected on the basis of Connecticut direct
367 written health premiums from such network plans.

368 (2) For the purposes of this section and sections 38a-477c, 38a-478c,
369 as amended by this act, and 38a-478g:

370 (A) "State medical loss ratio" means the ratio of incurred claims to
371 earned premiums for the prior calendar year for managed care plans
372 issued in the state. Claims shall be limited to medical expenses for
373 services and supplies provided to enrollees and shall not include
374 expenses for stop loss coverage, reinsurance, enrollee educational
375 programs or other cost containment programs or features;

376 (B) "Federal medical loss ratio" has the same meaning as provided
377 in, and shall be calculated in accordance with, the Patient Protection
378 and Affordable Care Act, P.L. 111-148, as amended from time to time,
379 and regulations adopted thereunder.

380 (c) [With respect to mental health services, the consumer report card
381 shall include information or measures with respect to the percentage of
382 enrollees receiving mental health services, utilization of mental health
383 and chemical dependence services, inpatient and outpatient
384 admissions, discharge rates and average lengths of stay.] (1) On or
385 before May first of each year, each health insurer that provides
386 coverage as set forth in section 38a-488a, as amended by this act, or
387 38a-514, as amended by this act, shall submit to the commissioner:

388 (A) Data for benefit requests, utilization review of benefit requests,
389 adverse determinations and final adverse determinations for the
390 treatment of acute and routine substance use disorders, co-occurring
391 disorders and mental disorders: (i) Grouped according to levels of
392 care, including, but not limited to, inpatient, outpatient, residential
393 care and partial hospitalization; (ii) grouped by category for substance

394 use disorders, co-occurring disorders and mental disorders; and (iii)
395 grouped by children, young adults and adults. For the purposes of this
396 subparagraph, "children" means individuals less than sixteen years of
397 age, "young adults" means individuals sixteen years of age or older but
398 less than twenty-six years of age and "adults" means individuals
399 twenty-six years of age or older; and

400 (B) Data for external appeals for the treatment of substance use
401 disorders, co-occurring disorders and mental disorders, grouped in
402 accordance with subparagraphs (A)(i) to (A)(iii), inclusive, of this
403 subdivision.

404 (2) Such data shall be collected in a manner consistent with the
405 National Committee for Quality Assurance Health Plan Employer Data
406 and Information Set measures.

407 (d) The commissioner shall test market a draft of the consumer
408 report card prior to its publication and distribution. As a result of such
409 test marketing, the commissioner may make any necessary
410 modification to its form or substance. The Insurance Department shall
411 prominently display a link to the consumer report card on the
412 department's Internet web site.

413 (e) The commissioner shall analyze annually the data submitted
414 under subparagraphs (E) and (F) of subdivision (1) of subsection (b) of
415 this section for the accuracy of, trends in and statistically significant
416 differences in such data among the health care centers and licensed
417 health insurers included in the consumer report card. The
418 commissioner may investigate any such differences to determine
419 whether further action by the commissioner is warranted.

420 Sec. 8. Section 38a-488a of the 2018 supplement to the general
421 statutes is repealed and the following is substituted in lieu thereof
422 (*Effective January 1, 2019*):

423 (a) For the purposes of this section: (1) "Mental or nervous
424 conditions" means mental disorders, as defined in the most recent

425 edition of the American Psychiatric Association's "Diagnostic and
426 Statistical Manual of Mental Disorders". "Mental or nervous
427 conditions" does not include (A) intellectual disability, (B) specific
428 learning disorders, (C) motor disorders, (D) communication disorders,
429 (E) caffeine-related disorders, (F) relational problems, and (G) other
430 conditions that may be a focus of clinical attention, that are not
431 otherwise defined as mental disorders in the most recent edition of the
432 American Psychiatric Association's "Diagnostic and Statistical Manual
433 of Mental Disorders"; (2) "benefits payable" means the usual,
434 customary and reasonable charges for treatment deemed necessary
435 under generally accepted medical standards, except that in the case of
436 a managed care plan, as defined in section 38a-478, "benefits payable"
437 means the payments agreed upon in the contract between a managed
438 care organization, as defined in section 38a-478, and a provider, as
439 defined in section 38a-478; (3) "acute treatment services" means
440 twenty-four-hour medically supervised treatment for a substance use
441 disorder, that is provided in a medically managed or medically
442 monitored inpatient facility; and (4) "clinical stabilization services"
443 means twenty-four-hour clinically managed postdetoxification
444 treatment, including, but not limited to, relapse prevention, family
445 outreach, aftercare planning and addiction education and counseling.

446 (b) Each individual health insurance policy providing coverage of
447 the type specified in subdivisions (1), (2), (4), (11) and (12) of section
448 38a-469 delivered, issued for delivery, renewed, amended or continued
449 in this state shall provide benefits for the diagnosis and treatment of
450 mental or nervous conditions. Benefits payable include, but need not
451 be limited to:

452 (1) General inpatient hospitalization, including in state-operated
453 facilities;

454 (2) Medically necessary acute treatment services and medically
455 necessary clinical stabilization services;

456 (3) General hospital outpatient services, including at state-operated
457 facilities;

458 (4) Psychiatric inpatient hospitalization, including in state-operated
459 facilities;

460 (5) Psychiatric outpatient hospital services, including at state-
461 operated facilities;

462 (6) Intensive outpatient services, including at state-operated
463 facilities;

464 (7) Partial hospitalization, including at state-operated facilities;

465 (8) Intensive, home-based services designed to address specific
466 mental or nervous conditions in a child;

467 (9) Evidence-based family-focused therapy that specializes in the
468 treatment of juvenile substance use disorders;

469 (10) Short-term family therapy intervention;

470 (11) Nonhospital inpatient detoxification;

471 (12) Medically monitored detoxification;

472 (13) Ambulatory detoxification;

473 (14) Inpatient services at psychiatric residential treatment facilities;

474 (15) Rehabilitation services provided in residential treatment
475 facilities, general hospitals, psychiatric hospitals or psychiatric
476 facilities;

477 (16) Observation beds in acute hospital settings;

478 (17) Psychological and neuropsychological testing conducted by an
479 appropriately licensed health care provider;

480 (18) Trauma screening conducted by a licensed behavioral health
481 professional;

482 (19) Depression screening, including maternal depression screening,

483 conducted by a licensed behavioral health professional;

484 (20) Substance use screening conducted by a licensed behavioral
485 health professional; and

486 (21) Screening for mental or nervous conditions during any annual
487 physical examination conducted by a licensed health care provider.

488 (c) No such policy shall establish any terms, conditions or benefits
489 that place a greater financial burden on an insured for access to
490 diagnosis or treatment of mental or nervous conditions than for
491 diagnosis or treatment of medical, surgical or other physical health
492 conditions, or prohibit an insured from obtaining or a health care
493 provider from being reimbursed for multiple screening services as part
494 of a single-day visit to a health care provider or a multicare institution,
495 as defined in section 19a-490.

496 (d) In the case of benefits payable for the services of a licensed
497 physician, such benefits shall be payable for the same services when
498 such services are lawfully rendered by a psychologist licensed under
499 the provisions of chapter 383 or by such a licensed psychologist in a
500 licensed hospital or clinic.

501 (e) In the case of benefits payable for the services of a licensed
502 physician or psychologist, such benefits shall be payable for the same
503 services when such services are rendered by:

504 (1) A clinical social worker who is licensed under the provisions of
505 chapter 383b and who has passed the clinical examination of the
506 American Association of State Social Work Boards and has completed
507 at least two thousand hours of post-master's social work experience in
508 a nonprofit agency qualifying as a tax-exempt organization under
509 Section 501(c) of the Internal Revenue Code of 1986 or any subsequent
510 corresponding internal revenue code of the United States, as from time
511 to time amended, in a municipal, state or federal agency or in an
512 institution licensed by the Department of Public Health under section
513 19a-490;

514 (2) A social worker who was certified as an independent social
515 worker under the provisions of chapter 383b prior to October 1, 1990;

516 (3) A licensed marital and family therapist who has completed at
517 least two thousand hours of post-master's marriage and family therapy
518 work experience in a nonprofit agency qualifying as a tax-exempt
519 organization under Section 501(c) of the Internal Revenue Code of 1986
520 or any subsequent corresponding internal revenue code of the United
521 States, as from time to time amended, in a municipal, state or federal
522 agency or in an institution licensed by the Department of Public Health
523 under section 19a-490;

524 (4) A marital and family therapist who was certified under the
525 provisions of chapter 383a prior to October 1, 1992;

526 (5) A licensed alcohol and drug counselor, as defined in section 20-
527 74s, or a certified alcohol and drug counselor, as defined in section 20-
528 74s;

529 (6) A licensed professional counselor; or

530 (7) An advanced practice registered nurse licensed under chapter
531 378.

532 (f) (1) In the case of benefits payable for the services of a licensed
533 physician, such benefits shall be payable for (A) services rendered in a
534 child guidance clinic or residential treatment facility by a person with a
535 master's degree in social work or by a person with a master's degree in
536 marriage and family therapy under the supervision of a psychiatrist,
537 physician, licensed marital and family therapist, or licensed clinical
538 social worker who is eligible for reimbursement under subdivisions (1)
539 to (4), inclusive, of subsection (e) of this section; (B) services rendered
540 in a residential treatment facility by a licensed or certified alcohol and
541 drug counselor who is eligible for reimbursement under subdivision
542 (5) of subsection (e) of this section; or (C) services rendered in a
543 residential treatment facility by a licensed professional counselor who
544 is eligible for reimbursement under subdivision (6) of subsection (e) of

545 this section.

546 (2) In the case of benefits payable for the services of a licensed
547 psychologist under subsection (e) of this section, such benefits shall be
548 payable for (A) services rendered in a child guidance clinic or
549 residential treatment facility by a person with a master's degree in
550 social work or by a person with a master's degree in marriage and
551 family therapy under the supervision of such licensed psychologist,
552 licensed marital and family therapist, or licensed clinical social worker
553 who is eligible for reimbursement under subdivisions (1) to (4),
554 inclusive, of subsection (e) of this section; (B) services rendered in a
555 residential treatment facility by a licensed or certified alcohol and drug
556 counselor who is eligible for reimbursement under subdivision (5) of
557 subsection (e) of this section; or (C) services rendered in a residential
558 treatment facility by a licensed professional counselor who is eligible
559 for reimbursement under subdivision (6) of subsection (e) of this
560 section.

561 (g) In the case of benefits payable for the service of a licensed
562 physician practicing as a psychiatrist or a licensed psychologist, under
563 subsection (e) of this section, such benefits shall be payable for
564 outpatient services rendered (1) in a nonprofit community mental
565 health center, as defined by the Department of Mental Health and
566 Addiction Services, in a nonprofit licensed adult psychiatric clinic
567 operated by an accredited hospital or in a residential treatment facility;
568 (2) under the supervision of a licensed physician practicing as a
569 psychiatrist, a licensed psychologist, a licensed marital and family
570 therapist, a licensed clinical social worker, a licensed or certified
571 alcohol and drug counselor or a licensed professional counselor who is
572 eligible for reimbursement under subdivisions (1) to (6), inclusive, of
573 subsection (e) of this section; and (3) within the scope of the license
574 issued to the center or clinic by the Department of Public Health or to
575 the residential treatment facility by the Department of Children and
576 Families.

577 (h) Except in the case of emergency services or in the case of services

578 for which an individual has been referred by a physician affiliated
579 with a health care center, nothing in this section shall be construed to
580 require a health care center to provide benefits under this section
581 through facilities that are not affiliated with the health care center.

582 (i) In the case of any person admitted to a state institution or facility
583 administered by the Department of Mental Health and Addiction
584 Services, Department of Public Health, Department of Children and
585 Families or the Department of Developmental Services, the state shall
586 have a lien upon the proceeds of any coverage available to such person
587 or a legally liable relative of such person under the terms of this
588 section, to the extent of the per capita cost of such person's care. Except
589 in the case of emergency services, the provisions of this subsection
590 shall not apply to coverage provided under a managed care plan, as
591 defined in section 38a-478.

592 (j) Reimbursement for covered services rendered in this state by an
593 out-of-network health care provider for the diagnosis or treatment of a
594 substance use disorder shall be paid under the insured's individual
595 health insurance policy directly to the provider if the provider is
596 otherwise eligible for reimbursement for such services. The insured
597 who received such services shall be deemed to have made an
598 assignment to such provider of such insured's coverage
599 reimbursement benefits and other rights under the policy. In no event
600 shall such provider bill, charge, collect a deposit from, seek
601 compensation, remuneration or reimbursement from or have any
602 recourse against the insured for such services, except that such
603 provider may collect any copayments, deductibles or other out-of-
604 pocket expenses that the insured is required to pay under the policy.

605 Sec. 9. Section 38a-514 of the 2018 supplement to the general statutes
606 is repealed and the following is substituted in lieu thereof (*Effective*
607 *January 1, 2019*):

608 (a) For the purposes of this section: (1) "Mental or nervous
609 conditions" means mental disorders, as defined in the most recent
610 edition of the American Psychiatric Association's "Diagnostic and

611 Statistical Manual of Mental Disorders". "Mental or nervous
612 conditions" does not include (A) intellectual disability, (B) specific
613 learning disorders, (C) motor disorders, (D) communication disorders,
614 (E) caffeine-related disorders, (F) relational problems, and (G) other
615 conditions that may be a focus of clinical attention, that are not
616 otherwise defined as mental disorders in the most recent edition of the
617 American Psychiatric Association's "Diagnostic and Statistical Manual
618 of Mental Disorders"; (2) "benefits payable" means the usual,
619 customary and reasonable charges for treatment deemed necessary
620 under generally accepted medical standards, except that in the case of
621 a managed care plan, as defined in section 38a-478, "benefits payable"
622 means the payments agreed upon in the contract between a managed
623 care organization, as defined in section 38a-478, and a provider, as
624 defined in section 38a-478; (3) "acute treatment services" means
625 twenty-four-hour medically supervised treatment for a substance use
626 disorder, that is provided in a medically managed or medically
627 monitored inpatient facility; and (4) "clinical stabilization services"
628 means twenty-four-hour clinically managed postdetoxification
629 treatment, including, but not limited to, relapse prevention, family
630 outreach, aftercare planning and addiction education and counseling.

631 (b) Except as provided in subsection (j) of this section, each group
632 health insurance policy providing coverage of the type specified in
633 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered,
634 issued for delivery, renewed, amended or continued in this state shall
635 provide benefits for the diagnosis and treatment of mental or nervous
636 conditions. Benefits payable include, but need not be limited to:

637 (1) General inpatient hospitalization, including in state-operated
638 facilities;

639 (2) Medically necessary acute treatment services and medically
640 necessary clinical stabilization services;

641 (3) General hospital outpatient services, including at state-operated
642 facilities;

643 (4) Psychiatric inpatient hospitalization, including in state-operated
644 facilities;

645 (5) Psychiatric outpatient hospital services, including at state-
646 operated facilities;

647 (6) Intensive outpatient services, including at state-operated
648 facilities;

649 (7) Partial hospitalization, including at state-operated facilities;

650 (8) Intensive, home-based services designed to address specific
651 mental or nervous conditions in a child;

652 (9) Evidence-based family-focused therapy that specializes in the
653 treatment of juvenile substance use disorders;

654 (10) Short-term family therapy intervention;

655 (11) Nonhospital inpatient detoxification;

656 (12) Medically monitored detoxification;

657 (13) Ambulatory detoxification;

658 (14) Inpatient services at psychiatric residential treatment facilities;

659 (15) Rehabilitation services provided in residential treatment
660 facilities, general hospitals, psychiatric hospitals or psychiatric
661 facilities;

662 (16) Observation beds in acute hospital settings;

663 (17) Psychological and neuropsychological testing conducted by an
664 appropriately licensed health care provider;

665 (18) Trauma screening conducted by a licensed behavioral health
666 professional;

667 (19) Depression screening, including maternal depression screening,

668 conducted by a licensed behavioral health professional;

669 (20) Substance use screening conducted by a licensed behavioral
670 health professional; <u>and</u>

671 <u>(21) Screening for mental or nervous conditions during any annual</u>
672 <u>physical examination conducted by a licensed health care provider.</u>

673 (c) No such group policy shall establish any terms, conditions or
674 benefits that place a greater financial burden on an insured for access
675 to diagnosis or treatment of mental or nervous conditions than for
676 diagnosis or treatment of medical, surgical or other physical health
677 conditions, or prohibit an insured from obtaining or a health care
678 provider from being reimbursed for multiple screening services as part
679 of a single-day visit to a health care provider or a multicare institution,
680 as defined in section 19a-490.

681 (d) In the case of benefits payable for the services of a licensed
682 physician, such benefits shall be payable for the same services when
683 such services are lawfully rendered by a psychologist licensed under
684 the provisions of chapter 383 or by such a licensed psychologist in a
685 licensed hospital or clinic.

686 (e) In the case of benefits payable for the services of a licensed
687 physician or psychologist, such benefits shall be payable for the same
688 services when such services are rendered by:

689 (1) A clinical social worker who is licensed under the provisions of
690 chapter 383b and who has passed the clinical examination of the
691 American Association of State Social Work Boards and has completed
692 at least two thousand hours of post-master's social work experience in
693 a nonprofit agency qualifying as a tax-exempt organization under
694 Section 501(c) of the Internal Revenue Code of 1986 or any subsequent
695 corresponding internal revenue code of the United States, as from time
696 to time amended, in a municipal, state or federal agency or in an
697 institution licensed by the Department of Public Health under section
698 19a-490;

699 (2) A social worker who was certified as an independent social
700 worker under the provisions of chapter 383b prior to October 1, 1990;

701 (3) A licensed marital and family therapist who has completed at
702 least two thousand hours of post-master's marriage and family therapy
703 work experience in a nonprofit agency qualifying as a tax-exempt
704 organization under Section 501(c) of the Internal Revenue Code of 1986
705 or any subsequent corresponding internal revenue code of the United
706 States, as from time to time amended, in a municipal, state or federal
707 agency or in an institution licensed by the Department of Public Health
708 under section 19a-490;

709 (4) A marital and family therapist who was certified under the
710 provisions of chapter 383a prior to October 1, 1992;

711 (5) A licensed alcohol and drug counselor, as defined in section 20-
712 74s, or a certified alcohol and drug counselor, as defined in section 20-
713 74s;

714 (6) A licensed professional counselor; or

715 (7) An advanced practice registered nurse licensed under chapter
716 378.

717 (f) (1) In the case of benefits payable for the services of a licensed
718 physician, such benefits shall be payable for (A) services rendered in a
719 child guidance clinic or residential treatment facility by a person with a
720 master's degree in social work or by a person with a master's degree in
721 marriage and family therapy under the supervision of a psychiatrist,
722 physician, licensed marital and family therapist or licensed clinical
723 social worker who is eligible for reimbursement under subdivisions (1)
724 to (4), inclusive, of subsection (e) of this section; (B) services rendered
725 in a residential treatment facility by a licensed or certified alcohol and
726 drug counselor who is eligible for reimbursement under subdivision
727 (5) of subsection (e) of this section; or (C) services rendered in a
728 residential treatment facility by a licensed professional counselor who
729 is eligible for reimbursement under subdivision (6) of subsection (e) of

730 this section.

731 (2) In the case of benefits payable for the services of a licensed
732 psychologist under subsection (e) of this section, such benefits shall be
733 payable for (A) services rendered in a child guidance clinic or
734 residential treatment facility by a person with a master's degree in
735 social work or by a person with a master's degree in marriage and
736 family therapy under the supervision of such licensed psychologist,
737 licensed marital and family therapist or licensed clinical social worker
738 who is eligible for reimbursement under subdivisions (1) to (4),
739 inclusive, of subsection (e) of this section; (B) services rendered in a
740 residential treatment facility by a licensed or certified alcohol and drug
741 counselor who is eligible for reimbursement under subdivision (5) of
742 subsection (e) of this section; or (C) services rendered in a residential
743 treatment facility by a licensed professional counselor who is eligible
744 for reimbursement under subdivision (6) of subsection (e) of this
745 section.

746 (g) In the case of benefits payable for the service of a licensed
747 physician practicing as a psychiatrist or a licensed psychologist, under
748 subsection (e) of this section, such benefits shall be payable for
749 outpatient services rendered (1) in a nonprofit community mental
750 health center, as defined by the Department of Mental Health and
751 Addiction Services, in a nonprofit licensed adult psychiatric clinic
752 operated by an accredited hospital or in a residential treatment facility;
753 (2) under the supervision of a licensed physician practicing as a
754 psychiatrist, a licensed psychologist, a licensed marital and family
755 therapist, a licensed clinical social worker, a licensed or certified
756 alcohol and drug counselor, or a licensed professional counselor who
757 is eligible for reimbursement under subdivisions (1) to (6), inclusive, of
758 subsection (e) of this section; and (3) within the scope of the license
759 issued to the center or clinic by the Department of Public Health or to
760 the residential treatment facility by the Department of Children and
761 Families.

762 (h) Except in the case of emergency services or in the case of services

763 for which an individual has been referred by a physician affiliated
764 with a health care center, nothing in this section shall be construed to
765 require a health care center to provide benefits under this section
766 through facilities that are not affiliated with the health care center.

767 (i) In the case of any person admitted to a state institution or facility
768 administered by the Department of Mental Health and Addiction
769 Services, Department of Public Health, Department of Children and
770 Families or the Department of Developmental Services, the state shall
771 have a lien upon the proceeds of any coverage available to such person
772 or a legally liable relative of such person under the terms of this
773 section, to the extent of the per capita cost of such person's care. Except
774 in the case of emergency services the provisions of this subsection shall
775 not apply to coverage provided under a managed care plan, as defined
776 in section 38a-478.

777 (j) A group health insurance policy may exclude the benefits
778 required by this section if such benefits are included in a separate
779 policy issued to the same group by an insurance company, health care
780 center, hospital service corporation, medical service corporation or
781 fraternal benefit society. Such separate policy, which shall include the
782 benefits required by this section and the benefits required by section
783 38a-533, shall not be required to include any other benefits mandated
784 by this title.

785 (k) In the case of benefits based upon confinement in a residential
786 treatment facility, such benefits shall be payable in situations in which
787 the insured has a serious mental or nervous condition that
788 substantially impairs the insured's thoughts, perception of reality,
789 emotional process or judgment or grossly impairs the behavior of the
790 insured, and, upon an assessment of the insured by a physician,
791 psychiatrist, psychologist or clinical social worker, cannot
792 appropriately, safely or effectively be treated in an acute care, partial
793 hospitalization, intensive outpatient or outpatient setting.

794 (l) The services rendered for which benefits are to be paid for
795 confinement in a residential treatment facility shall be based on an

796 individual treatment plan. For purposes of this section, the term
797 "individual treatment plan" means a treatment plan prescribed by a
798 physician with specific attainable goals and objectives appropriate to
799 both the patient and the treatment modality of the program.

800 (m) Reimbursement for covered services rendered in this state by an
801 out-of-network health care provider for the diagnosis or treatment of a
802 substance use disorder shall be paid under the insured's group health
803 insurance policy directly to the provider if the provider is otherwise
804 eligible for reimbursement for such services. The insured who received
805 such services shall be deemed to have made an assignment to such
806 provider of such insured's coverage reimbursement benefits and other
807 rights under the policy. In no event shall such provider bill, charge,
808 collect a deposit from, seek compensation, remuneration or
809 reimbursement from or have any recourse against the insured for such
810 services, except that such provider may collect any copayments,
811 deductibles or other out-of-pocket expenses that the insured is
812 required to pay under the policy.

813 Sec. 10. Section 19a-754a of the 2018 supplement to the general
814 statutes is repealed and the following is substituted in lieu thereof
815 (*Effective January 1, 2019*):

816 (a) There is established an Office of Health Strategy, which shall be
817 within the Department of Public Health for administrative purposes
818 only. The department head of said office shall be the executive director
819 of the Office of Health Strategy, who shall be appointed by the
820 Governor in accordance with the provisions of sections 4-5 to 4-8,
821 inclusive, with the powers and duties therein prescribed.

822 (b) On or before July 1, 2018, the Office of Health Strategy shall be
823 responsible for the following:

824 (1) Developing and implementing a comprehensive and cohesive
825 health care vision for the state, including, but not limited to, a
826 coordinated state health care cost containment strategy;

827 (2) Directing and overseeing (A) the all-payers claims database
828 program established pursuant to section 19a-755a, and (B) the State
829 Innovation Model Initiative and related successor initiatives;

830 (3) Coordinating the state's health information technology
831 initiatives;

832 (4) Directing and overseeing the Office of Health Care Access and
833 all of its duties and responsibilities as set forth in chapter 368z; and

834 (5) Convening forums and meetings with state government and
835 external stakeholders, including, but not limited to, the Connecticut
836 Health Insurance Exchange, to discuss health care issues designed to
837 develop effective health care cost and quality strategies.

838 (c) Not later than June 30, 2019, and quarterly thereafter until and
839 including March 31, 2021, the Office of Health Strategy shall report to
840 the joint standing committees of the General Assembly having
841 cognizance of matters relating to public health and insurance on the
842 activities the office has undertaken and the progress the office has
843 made to have the all-payer claims database, as defined in section 19a-
844 755a, provide the data described in subdivisions (7) to (11), inclusive,
845 of subsection (a) of section 38a-478c, as amended by this act, and
846 subdivision (1) of subsection (c) of section 38a-478*l*, as amended by this
847 act.

848 **[**(c)**]** (d) The Office of Health Strategy shall constitute a successor, in
849 accordance with the provisions of sections 4-38d, 4-38e and 4-39, to the
850 functions, powers and duties of the following:

851 (1) The Connecticut Health Insurance Exchange, established
852 pursuant to section 38a-1081, relating to the administration of the all-
853 payer claims database pursuant to section 19a-755a; and

854 (2) The Office of the Lieutenant Governor, relating to the (A)
855 development of a chronic disease plan pursuant to section 19a-6q, (B)
856 housing, chairing and staffing of the Health Care Cabinet pursuant to
857 section 19a-725, and (C) (i) appointment of the health information

858 technology officer pursuant to section 19a-755, and (ii) oversight of the
859 duties of such health information technology officer as set forth in
860 sections 17b-59, 17b-59a and 17b-59f.

861 **[**(d)**]** (e) Any order or regulation of the entities listed in subdivisions
862 (1) and (2) of subsection **[**(c)**]** (d) of this section that is in force on July 1,
863 2018, shall continue in force and effect as an order or regulation until
864 amended, repealed or superseded pursuant to law.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2019*	New section
Sec. 2	*January 1, 2019*	New section
Sec. 3	*January 1, 2019*	New section
Sec. 4	*January 1, 2019*	New section
Sec. 5	*January 1, 2019*	New section
Sec. 6	*January 1, 2019*	38a-478c
Sec. 7	*January 1, 2019*	38a-478*l*
Sec. 8	*January 1, 2019*	38a-488a
Sec. 9	*January 1, 2019*	38a-514
Sec. 10	*January 1, 2019*	19a-754a

Statement of Legislative Commissioners:

In Section 1(10), "or "medical necessity"" was deleted for statutory consistency and Section 6(a)(10) was rewritten for clarity.

INS *Joint Favorable Subst.*

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 19 $	FY 20 $
State Comptroller - Fringe Benefits	GF&TF - Potential Cost	See Below	See Below

Note: GF&TF=General Fund & Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 19 $	FY 20 $
Various Municipalities	Potential Cost	See Below	See Below

The bill may result in a cost to the state employee and retiree health plan as well as fully insured municipal plans to the extent that the bill increases utilization of mental health screening services pursuant to section 9(b)(21) of the bill. The potential cost will accrue to the state and municipalities to the extent screenings are conducted during a physical exam or as a result of a referral to another licensed practitioner. The plan currently limits coverage for mental health services to those "…provided by Providers who are certified by the appropriate state agency to provide such services and whose programs for such services have been approved by the Carrier."[1] It is uncertain if screening for a mental or nervous condition as defined by CGS § 38a-488a would be covered at an annual physical exam. Under current law, three screenings specified (e.g. trauma screening, substance use screening, and depression screening) require coverage conducted by a licensed behavioral health professional (CGS §38a-488). The bill does not define "screening". The fiscal impact to fully-insured municipalities will be

[1] Source: *State of Connecticut Health Benefit Plan – Plan Document.*

reflected in premiums for plan years effective on or after January 1, 2019. Due to federal law, self-insured plans are exempt from state health mandates.[2]

The bill's various reporting requirements are not anticipated to result in a fiscal impact to the state or municipal health plans.

The bill is not anticipated to result in a fiscal impact to the Insurance Department from expanded data collection, analysis and reporting requirements. The provisions are similar to existing Department activities and fall within Department's expertise.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to the utilization of services and for fully-insured municipalities, will be reflected in future premiums.

[2] The state employee and non-Medicare retiree health plan are self-insured and therefore are exempt from state health mandates. However, the state has traditionally adopted all state mandated benefits. Self-insured municipalities are likewise exempt from state health mandates.

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)