House of Representatives

File No. 966

General Assembly

January Session, 2019

(Reprint of File No. 343)

Substitute House Bill No. 7125
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
May 22, 2019

AN ACT CONCERNING MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

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

Section 1. (NEW) (*Effective October 1, 2019*) (a) For the purposes of this section:

(1) "Health carrier" has the same meaning as provided in section 38a-1080 of the general statutes;

(2) "Mental health and substance use disorder benefits" means all benefits for the treatment of a mental health condition or a substance use disorder that (A) falls under one or more of the diagnostic categories listed in the chapter concerning mental disorders in the most recent edition of the International Classification of Diseases, or (B) is a mental disorder, as that term is defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders"; and

(3) "Nonquantitative treatment limitation" means a limitation that

cannot be expressed numerically but otherwise limits the scope or duration of a covered benefit.

(b) Not later than March 1, 2021, and annually thereafter, each health carrier shall submit a report to the Insurance Commissioner, in a form and manner prescribed by the commissioner, containing the following information for the calendar year immediately preceding:

(1) A description of the processes that such health carrier used to develop and select criteria to assess the medical necessity of (A) mental health and substance use disorder benefits, and (B) medical and surgical benefits;

(2) A description of all nonquantitative treatment limitations that such health carrier applied to (A) mental health and substance use disorder benefits, and (B) medical and surgical benefits; and

(3) The results of an analysis concerning the processes, strategies, evidentiary standards and other factors that such health carrier used in developing and applying the criteria described in subdivision (1) of this subsection and each nonquantitative treatment limitation described in subdivision (2) of this subsection, provided the commissioner shall not disclose such results in a manner that is likely to compromise the financial, competitive or proprietary nature of such results. The results of such analysis shall, at a minimum:

(A) Disclose each factor that such health carrier considered, regardless of whether such health carrier rejected such factor, in (i) designing each nonquantitative treatment limitation described in subdivision (2) of this subsection, and (ii) determining whether to apply such nonquantitative treatment limitation;

(B) Disclose any and all evidentiary standards, which standards may be qualitative or quantitative in nature, applied under a factor described in subparagraph (A) of this subdivision, and, if no evidentiary standard is applied under such a factor, a clear description of such factor;

(C) Provide the comparative analyses, including the results of such analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the processes and strategies used to apply such nonquantitative treatment limitation, as written, to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, and the processes and strategies used to apply such nonquantitative treatment limitation, as written, to medical and surgical benefits;

(D) Provide the comparative analyses, including the results of such analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, to medical and surgical benefits; and

(E) Disclose information that, in the opinion of the Insurance Commissioner, is sufficient to demonstrate that such health carrier, consistent with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, as amended from time to time, and regulations adopted thereunder, (i) applied each nonquantitative treatment limitation described in subdivision (2) of this subsection comparably, and not more stringently, to (I) mental health and substance use disorder benefits, and (II) medical and surgical benefits, and (ii) complied with (I) sections 2 and 3 of this act, (II) sections 38a-488a and 38a-514 of the general statutes, (III) sections 38a-510 and 38a-544 of the general statutes, and (IV) the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, as amended from time to time, and regulations adopted thereunder.

(c) (1) Not later than April 15, 2021, and annually thereafter, the Insurance Commissioner shall submit each report that the

commissioner received pursuant to subsection (b) of this section for the calendar year immediately preceding to:

(A) The joint standing committee of the General Assembly having cognizance of matters relating to insurance, in accordance with section 11-4a of the general statutes; and

(B) The Attorney General, Healthcare Advocate and executive director of the Office of Health Strategy.

(2) Notwithstanding subdivision (1) of this subsection, the commissioner shall not submit the name or identity of any health carrier or entity that has contracted with such health carrier, and such name or identity shall be given confidential treatment and not be made public by the commissioner.

(d) Not later than May 15, 2021, and annually thereafter, the joint standing committee of the General Assembly having cognizance of matters relating to insurance may hold a public hearing concerning the reports that such committee received pursuant to subsection (c) of this section for the calendar year immediately preceding. The Insurance Commissioner, or the commissioner's designee, shall attend the public hearing and inform the committee whether, in the commissioner's opinion, each health carrier, for the calendar year immediately preceding, (1) submitted a report pursuant to subsection (b) of this section that satisfies the requirements established in said subsection, and (2) complied with (A) sections 2 and 3 of this act, (B) sections 38a-488a and 38a-514 of the general statutes, (C) sections 38a-510 and 38a-544 of the general statutes, and (D) the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, as amended from time to time, and regulations adopted thereunder.

(e) Nothing in this section shall be construed to require any disclosure in violation of (1) 42 USC 290dd-2, as amended from time to time, (2) 42 USC 1320d et seq., as amended from time to time, (3) 42 CFR 2, as amended from time to time, and (4) 45 CFR 160.101 to

164.534, inclusive, as amended from time to time.

(f) The Insurance Commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 2. (NEW) (*Effective January 1, 2020*) No individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2020, shall apply a nonquantitative treatment limitation to mental health and substance use disorder benefits unless such policy applies such limitation to such benefits in a manner that is comparable to, and not more stringent than, the manner in which such policy applies such limitation to medical and surgical benefits. For the purposes of this section, "nonquantitative treatment limitation" and "mental health and substance use disorder benefits" have the same meaning as provided in section 1 of this act.

Sec. 3. (NEW) (*Effective January 1, 2020*) No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2020, shall apply a nonquantitative treatment limitation to mental health and substance use disorder benefits unless such policy applies such limitation to such benefits in a manner that is comparable to, and not more stringent than, the manner in which such policy applies such limitation to medical and surgical benefits. For the purposes of this section, "nonquantitative treatment limitation" and "mental health and substance use disorder benefits" have the same meaning as provided in section 1 of this act.

Sec. 4. (NEW) (*Effective January 1, 2020*) No individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general

statutes that is delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2020, shall deny coverage for covered substance abuse services solely because such substance abuse services were provided pursuant to an order issued by a court of competent jurisdiction.

Sec. 5. (NEW) (*Effective January 1, 2020*) No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes that is delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2020, shall deny coverage for covered substance abuse services solely because such substance abuse services were provided pursuant to an order issued by a court of competent jurisdiction.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2019*	New section
Sec. 2	*January 1, 2020*	New section
Sec. 3	*January 1, 2020*	New section
Sec. 4	*January 1, 2020*	New section
Sec. 5	*January 1, 2020*	New section

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 20 $	FY 21 $
State Comptroller - Fringe Benefits[1]	GF, TF - Cost	At least $xx	At least $xx

Municipal Impact:

Municipalities	Effect	FY 20 $	FY 21 $
Various Municipalities	STATE MANDATE[2] - Cost	See Below	See Below

Explanation

Section 1 of the bill is not anticipated to result in a cost to the Insurance Department to comply with the requirements of the amendment as the agency has the expertise to do so.

Sections 2 and 4 do not result in a fiscal impact to the state or municipalities as they pertain to individual health insurance policies.

Section 3 does not result in a fiscal impact to the state or municipalities as it codifies federal law.

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 41.19% of payroll in FY 20 and FY 21.

[2] State mandate is defined in Sec. 2-32b(2) of the Connecticut General Statutes, "state mandate" means any state initiated constitutional, statutory or executive action that requires a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

Section 5 will result in a cost to the state and municipal health plans to the extent services are required to be covered for court ordered services that otherwise would have been excluded. The cost will depend on the mix of services and utilization. Under the state plan, court ordered services that have been ordered as a condition of probation or parole are generally not covered by the plan.

The cost to fully-insured municipal plans to comply with the provisions of section 5 of the bill will be reflected in premiums for policy years beginning on and after January 1, 2020. Pursuant to federal law, self-insured plans are exempt from state health insurance mandates.[3]

In addition, many municipal health plans are recognized as "grandfathered" health plans under the Affordable Care Act (ACA).[4] It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA.

House "A" replaces the original language of the bill and results in the fiscal impact indicated above.

The Out Years

The annualized ongoing fiscal impact above will continue into the future: (1) based on the mix and utilization of services provided, and (2) for fully-insured municipalities, will be reflected in future premiums.

[3] The state employee and retiree health plan is self-insured; however, the plan has historically adopted all health insurance mandates.

[4] Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010.

OLR Bill Analysis

sHB 7125 (as amended by House "A")*

AN ACT CONCERNING MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

SUMMARY

This bill prohibits certain health insurance policies from:

1. applying nonquantitative treatment limitations (i.e., non-numeric limits on the scope or duration of coverage) to mental health and substance use disorder benefits unless the policy applies the limitations comparably to, and not more stringently than, how it applies them to medical and surgical benefits (§§ 2 & 3) and

2. denying coverage for substance abuse services and prescribed treatment drugs solely because the services were provided under a court order (§§ 4 & 5).

These provisions apply to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2020, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan.

The bill also requires health carriers (e.g., insurers) to report, annually by March 1, 2021, information to the insurance commissioner that demonstrates, among other things, their compliance with state and federal mental health parity laws.

Starting May 15, 2021, the bill allows the Insurance and Real Estate

Committee to annually hold a public hearing about these reports. If it does so, the insurance commissioner or his designee must attend.

*House Amendment "A" removes provisions in the underlying bill that would have (1) required certain health insurance policies to cover prescription drugs used to treat substance use disorders and place such drugs in the lowest cost sharing tier and (2) prohibited policies from requiring step therapy or prior authorization for these drugs. The amendment also (1) requires the underlying bill's health carrier reports to include information demonstrating compliance with state prescription drug and federal mental health parity laws and (2) specifies that certain reported information is confidential.

EFFECTIVE DATE: January 1, 2020, except the reporting provisions are effective October 1, 2019.

§ 1 — MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS AND NONQUANTITATIVE TREATMENT LIMITATIONS REPORTING REQUIREMENT

Starting by March 1, 2021, the bill requires each health carrier to annually report to the insurance commissioner about mental health and substance use disorder benefits and nonquantitative treatment limitations. The report must be in a form and manner the commissioner prescribes and contain, for the prior calendar year, certain policy descriptions and analyses.

The bill authorizes the insurance commissioner to adopt implementing regulations.

Descriptions

The bill requires each health carrier to include in its report a description of:

1. the process used to develop and select criteria to assess the medical necessity of (a) mental health and substance use disorder benefits and (b) medical and surgical benefits and

2. all nonquantitative treatment limitations applied to mental health, substance use disorder, and medical and surgical benefits.

For the bill's purposes, "mental health and substance use disorder benefits" are all benefits used to treat a mental health condition or substance use disorder that is (1) listed as a mental disorder in the International Classification of Diseases or (2) a mental disorder as defined by the American Psychiatric Association.

Analysis

The report must also contain an analysis of the process, strategies, evidentiary standards, and other factors the health carrier used to develop and apply the medical necessity criteria and nonquantitative treatment limitations contained in the report. The analyses must disclose information that, in the commissioner's opinion, sufficiently demonstrates that the carrier:

1. applied nonquantitiative treatment limitations comparably, and not more stringently, to mental health and substance use disorder benefits and medical and surgical benefits consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act;

2. applied nonquantitative treatment limitations equally across mental health, substance use, and medical and surgical benefits; and

3. complied with state mental and nervous conditions coverage, prescription drug coverage, step therapy laws, and federal mental health parity laws.

The analysis must also:

1. disclose each factor the health carrier considered, regardless of whether it was accepted or rejected, in designing and determining whether to apply nonquantitive treatment

limitations;

2. disclose all evidentiary standards, whether quantitative or qualitative, applied under a factor considered above, or provide a clear description of the factor if no evidentiary standard was used;

3. provide the comparative analyses, including their results, that show that the written processes and strategies used to design and apply nonquantitative treatment limitations, as written, to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those used to design and apply nonquantitative treatment limitations, as written, to medical and surgical benefits; and

4. provide the comparative analyses that show the processes and strategies used to apply nonquantitative treatment limitations, in operation, to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those used to apply nonquantitative treatment limitations, in operation, to medical and surgical benefits.

Insurance Commissioner Annual Report

Starting by April 15, 2021, the commissioner must annually submit the reports he receives to the Insurance and Real Estate Committee as well as the attorney general, healthcare advocate, and the Office of Health Strategy's executive director. Under the bill, the health carrier's names and identities, including the names and identities of entities they contract with, are confidential, and the commissioner is prohibited from making them public.

The commissioner is also prohibited from disclosing the results of the analysis in a manner likely to compromise their financial, competitive, or proprietary nature.. The bill specifies that it does not require any disclosure in violation of federal confidentiality laws.

Insurance and Real Estate Committee Hearing

The bill allows the Insurance and Real Estate Committee to hold a public hearing on the reports. The insurance commissioner or his designee must attend and inform the committee whether, in his opinion, each health carrier (1) submitted the required reports; (2) applied nonquantitative treatment limitations equally across mental health, substance use, and medical and surgical benefits; and (3) complied with certain state mental and nervous conditions coverage, prescription drug coverage, step therapy laws, and federal mental health parity laws.

BACKGROUND

Legislative History

The House referred the bill (File 343) to the Appropriations Committee, which favorably reported it out on May 13, 2019.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 20 Nay 0 (03/19/2019)

Appropriations Committee

Joint Favorable
Yea 40 Nay 4 (05/13/2019)