



**PA 19-159**—sHB 7125

*Insurance and Real Estate Committee  
Appropriations Committee*

**AN ACT CONCERNING MENTAL HEALTH AND SUBSTANCE USE  
DISORDER BENEFITS**

**SUMMARY:** This act prohibits certain health insurance policies from:

1. applying nonquantitative treatment limitations (i.e., non-numeric limits on the scope or duration of coverage, such as prior authorization requirements) 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 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 act also requires health carriers (e.g., insurers) to annually report, starting by March 1, 2021, specified information to the insurance commissioner that demonstrates, among other things, their compliance with state and federal mental health parity laws (§ 1). The act authorizes the insurance commissioner to adopt implementing regulations.

The act allows the Insurance and Real Estate Committee to hold an annual public hearing about these reports. If it does so, the insurance commissioner or his designee must attend.

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

**MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS AND  
NONQUANTITATIVE TREATMENT LIMITATIONS REPORTING  
REQUIREMENT**

Starting by March 1, 2021, the act 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, for the prior calendar year, describe the health carrier's:

1. 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

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

The report must also analyze the process, strategies, evidentiary standards, and other factors that the health carrier used to develop and apply the criteria and limitations described above. (However, the act prohibits the insurance commissioner from disclosing the results in a manner likely to compromise their financial, competitive, or proprietary nature.) This analysis must:

1. disclose (a) each factor the health carrier considered, regardless of whether it was used, in designing and determining whether to apply nonquantitative treatment limitations and (b) all quantitative and qualitative evidentiary standards applied under these factors, or if none was used, a clear description of the factor and
2. provide the comparative analyses that show that the processes and strategies used to design and apply nonquantitative treatment limitations, as written and in operation, to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those used to design and apply such limitations to medical and surgical benefits.

The analysis must, in the commissioner's opinion, demonstrate that the carrier:

1. applied nonquantitative 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 (which generally prohibits insurers from applying more restrictive limitations on mental health and substance use benefits than they apply on medical and surgical benefits);
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, and step therapy laws, and federal mental health parity laws.

### *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. The act prohibits the commissioner from including any health carriers' names and identities, including the names and identities of entities with which they contract. It deems such information confidential and prohibits the commissioner from making it public. Additionally, the act specifies that it does not require any disclosure in violation of federal confidentiality laws.

### *Insurance and Real Estate Committee Hearing*

The act allows the Insurance and Real Estate Committee to hold a public

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hearing on the reports by May 15, 2021, and then annually after that. The insurance commissioner or his designee must attend and inform the committee whether, in his opinion, each health carrier (1) submitted the required report; (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.