



STATE OF CONNECTICUT

INSURANCE DEPARTMENT

A Report on Mental Health Parity And Commercial Health Insurance Compliance



**Prepared By
The Connecticut Insurance Department (CID)
For
The Insurance and Real Estate and Public Health
Committees**

December 31, 2013

To Senator Joseph Crisco and Senator Terry Gerratana;
Representative Robert Megna and Representative Susan Johnson;
And Esteemed Members of the Insurance & Real Estate Committee and the
Public Health Committee:

The Connecticut Insurance Department is presenting this report consistent with Section 79 of Connecticut Public Act 13-3. The statute requests the Department methodology for monitoring carrier compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), including final regulations issued on November 8, 2013 and for monitoring mental health parity compliance under state insurance laws. The report also provides details on the Department's regulatory and educational approaches relating to insurer reimbursement for mental health services in the state.

Aided by the checks and balances that exist among the divisions of Life & Health, Consumer Affairs and Market Conduct, the Department has a robust process of regulation. We recognize, however, that many in Connecticut face challenges in accessing mental health coverage.

To the extent where the Department has jurisdiction – over roughly one half of the commercially insured population – we have undertaken a comprehensive review of our procedures with the overriding goal of protecting policyholders.

That is what we do. That is our mission.

Each year, the Department recovers more than \$4 million on behalf of consumers and returns an average of \$100 million to the state General Fund in fines, license fees, premium taxes and other revenue sources to support various state programs, including childhood immunization.

In this report, we have identified areas of improvement and embraced opportunities for new initiatives. Our regulatory process has been enhanced over the past two years by pro-active Department initiatives, solid recommendations from the Legislature's Program Review & Investigations Committee, Public Act 13-3 and ongoing collaboration with fellow state agencies, the medical community and other stakeholders.

The Department takes its oversight role most seriously in regulating compliance with the laws that provide for access and payment for mental and behavioral health treatment for Connecticut citizens and welcomes the opportunity to share this information with you.

Respectfully,

Thomas B. Leonardi, Commissioner

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Background

The area of financial and treatment equity for mental health and substance abuse patients covered under commercial health insurance is a mission of the Connecticut Insurance Department (CID). CID has taken a very pro-active approach in ensuring compliance with mental health parity long in advance of Public Act 13-3 Section 79.

CID Regulatory Scope

The regulatory span of the Department of Insurance is that of the commercial insurance market. CID does not oversee self-insured plans, such as that for State of Connecticut employees or large employers or municipalities which choose to self insure (such plans are regulated by the U.S. Department of Labor). Nor does CID's scope extend to overseeing Federal programs such as Medicaid or Medicare (regulated by Centers for Medicare and Medicaid Services). Further, the CID does not have authority over the licensing or disciplining of healthcare providers (such authority resides with the Connecticut Department of Public Health).

Mental Health Parity Laws *(Appendix A)*

State laws enacted in 2000: Connecticut has had mental health parity statutes for individual and group health insurance since January 1, 2000, seven years before the federal Wellstone law (MHPAEA). As a result of this legislation, Connecticut has been on the forefront of mental health parity for many years, and the CID has aggressively enforced these laws.

State laws require all individual and group health insurance policies covering hospital, medical-surgical, major medical and HMO coverage which are delivered or issued in Connecticut to provide mental health benefits. State law also prohibits any policy terms that place a greater financial burden on an insured for access to diagnosis or treatment of mental health conditions than for medical conditions.

Note: The federal Affordable Care Act, enacted on March 23, 2010, requires individual and small group plans beginning January 1, 2014, to cover mental health benefits, a provision already in effect under Connecticut state law.

Federal Law (MHPAEA)

Federal MHPAEA enacted in 2008. The federal Mental Health Parity and Addiction Equity Act (MHPAEA) mandates that large group plans be compliant with mental health parity if mental health benefits are provided. It did not apply to individual or small groups.

The federal regulations provide requirements for health insurers relating to:

- **Financial and quantitative limitations** which are clear and relatively easy for the CID and other regulators to implement (e.g. co-pays, daily limits or dollar limits)
- **Non-quantitative treatment limitations**, which are more complicated to apply. (examples provided on page five of this report)

The federal government's interim regulations issued February 2, 2010 provided little clarity in the area that generates the most inquiries and confusion: non-quantitative treatment limits. Public input the Department received also underscored the need for more clarity, such as this Oct. 15, 2013 public comment from a parity coalition: *"The signatories believe that the major issues with MHPAEA enforcement here (and elsewhere) centers on non-quantitative limitations (NQTL) as described in the Interim Final Rule (IFR) and lack of clarity on whether plans must provide comparable types and levels of care between behavioral and medical plans."* (See Appendix L.)

Final regulations were announced on November 8, 2013 which presented few material changes, but did offer more clarity and more examples.

Financial and Quantitative Requirements

The federal rules provide for six categories of benefits over which to assess parity:

1. Inpatient, in-network
2. Inpatient, out-of-network
3. Outpatient, in-network
4. Outpatient, out-of-network
5. Emergency care
6. Prescription drugs.

In addition under the final regulations, office visits can be split out as a subclassification separate from outpatient services. The final regulations also specifically prohibit subclassifications for generalists and specialists.

Within each of the six categories a health insurer is prohibited from imposing:

- A financial requirement, such as a co-payment or coinsurance that is higher for mental health services than for substantially all medical services
- A quantitative treatment limitation, such as number of outpatient visits or inpatient days that are more restrictive for mental health services than for substantially all medical services
- Quantitative treatment limitations that apply more stringently to mental health services than to at least two-thirds of medical/surgical benefits in the same category.

Differing financial requirements and quantitative limits for mental health and substance abuse services can be spotted with ease by CID examiners when reviewing insurers'

policy forms, as they stand out. Forms that violate these mental health standards are not approved by the Department. (See Table 1, Life & Health Division)

Non-Quantitative Treatment Limitations (NQTLs)

According to federal law, parity between mental health benefits and all other types of health benefits must be exhibited among the following categories:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether a treatment is experimental or investigative
- Formulary design for prescriptions drugs
- Standards for provider admission to participate in network, including reimbursement rates for contracted providers
- Plan methods used to determine usual, customary, and reasonable fee charges (for out-of-network benefits)
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols)
- Exclusions based on failure to complete a course of treatment

These provisions listed as examples above are not prohibited outright, but rather are prohibited when applied more stringently to mental health benefits than to substantially all medical benefits.

These NQTLs, particularly the medical management standards, are more difficult for insurance regulators which do not have statutory authority over carriers' medical protocols nor do they have the medical or psychiatric expertise in-house to comprehensively review the insurers' medical protocols. Notwithstanding, CID has developed a number of steps (described later herein), to ensure health insurers handle these medical management and other NQTL requirements properly, consistently and in accordance with the law and regulations.

CID Oversight, Initiatives and Outreach

The activities undertaken on a team coordinated approach within the Department to oversee carrier behavior and ensure compliance are as follows:

In the normal course of the regulatory process the CID will utilize the following tools:

1) **Review of policy form filings.**

All policies to be sold in Connecticut must be filed for prior approval. The Life and Health (L&H) Division reviews policies, certificates and schedules of benefits carefully to ensure there is no provision that violates mental health parity for either quantitative or non-quantitative measures. Specific language

for grievance and external appeal rights is required in all contracts and reviewed for compliance.

Table 1 – Life & Health Division Reviews

2013	Form Filings	UR Licenses
2 L&H Examiners	160	63

2) **Grievances and external appeals procedures**

[Bulletin HC-92](#) (*Appendix B*) released June 2013 advised insurance companies and utilization review companies of the changes required effective October 1, 2013 in handling grievance and appeals as required under Public Act 13-3.

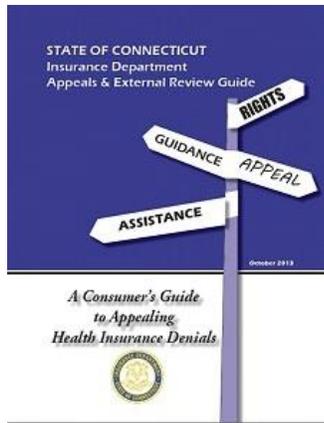
These included:

- New medical criteria standards for insurers to use when evaluating requests for behavioral health services
- A requirement for insurers to use clinical reviewers with certification and background in a similar field as the service being requested
- Shorter 24 hour turnaround times for reviewing urgent requests for behavioral health services

To ensure compliance, every individual complaint received in the Department’s Consumer Affairs Unit is reviewed for insurance company adherence to these strict new guidelines.

During the 2013 Legislative Session, the Department strongly advocated for appropriate and current mental health criteria during the drafting of PA 13-3. However, final language in the bill used out-dated criteria. The Department understands that “corrective” legislation will be submitted in the 2014 session. Moving forward, the Department respectfully suggests in order to avoid similar outcomes that’ legislators and advocates strongly consider consulting the Department when crafting legislation that impacts Connecticut insurance statutes.

Also effective October 1, 2013, several changes were made to the External Review process administered by CID. This included the requirement for an expedited 24 hour determination for certain Behavioral Health service denials. Consumer Affairs Unit worked with the insurance companies as well as the Independent Review Organizations contracted with to make the external review determinations, to ensure a smooth transition to the new requirements. To accommodate the changes brought about under Public Act 13-3 an updated [Consumer Guide and External Review Application](#) (*Appendix C*) were created and gave more in-depth direction to consumers with special focus on the new mental health protections.



3) Free assistance and advocacy of the Consumer Affairs Unit

Each year the Consumer Affairs Unit helps recover more than \$4 million on behalf of consumers for all types of insurance. In the past two years, the Consumer Affairs Unit has helped recover more than \$1.3 million for consumers with health insurance issues.

Table 2 – Consumer Affairs Unit Recovery on Health Insurance Complaints

Recovery/Number of Complaints	1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter	Totals	Average Recovery
2012	\$320,750/ 91	\$543,000/ 89	\$678,000/ 120	\$560,500/102	\$2.1M/ 402	\$5,220
2013	\$1M/ 79	\$270,750/ 96	\$348,850/ 90	N/A*	\$1.6M/ 265	\$6,400

These recovered funds are the direct result of consumer complaints that have been handled by the Consumer Affairs Unit and where the Consumer Affairs Unit identified additional money owed the consumer. Recoveries come in various forms, but a few examples include

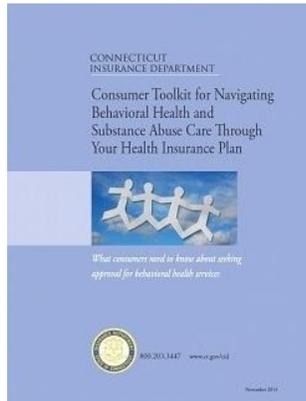
- Reimbursement for denied medical treatment
- Improper claim denial
- Improperly rescinded policy

The Consumer Affairs Unit works to identify inappropriate behavior on the part of insurers and requires them to make proper restitution for all consumers who may have been harmed, not just those who have proactively complained. Its oversight efforts and interactions also have a positive “sentinel effect” on the behavior of the industry.

Raising awareness

A marketing/advertising program slated to begin early in 2014 has been undertaken to increase consumer awareness of services offered by the Insurance Department to Connecticut citizens.

Behavioral Health Consumer Toolkit (Appendices D & E)



CID identified the need for clearer consumer guidance on navigating behavioral health and substance abuse care through their insurance plans. As a result, the CID collaborated with the industry and leveraged UConn Health Center psychiatry expertise to develop a Behavioral Health Consumer Toolkit to help policyholders secure coverage through their commercial insurer. The Tool Kit is featured prominently on the [CID Web site](#) and hundreds of hard copies are distributed at consumer outreach events. The Department has also asked health insurance companies to include it as a link on their Web sites. Further, Commissioner Mullen of the Department of Public Health has agreed to post the Toolkit on the Department of Public Health website and to send a joint letter with Deputy Commissioner Dowling to mental health and medical provider associations introducing the toolkit.

Industry Initiatives

Working with the Industry in preparing the toolkit has facilitated dialogue about behavioral health issues that carriers are seeing and brought forth many examples of effective mental health program initiatives by the insurance companies to help their members with those issues. This helps Consumer Affairs Unit to bring these programs to the attention of consumers.

Claim Denial Notifications

All claim denials notifications to plan members are required to list contact information for both the Connecticut Insurance Department and the Office of Healthcare Advocate (OHA) for assistance in challenging the denial. During the complaint handling process by the Insurance Department, consumers are advised of their rights under their insurance

contracts. Complaint investigation is undertaken to make sure that the insurance companies are following all statutes and regulations.

OHA Referrals

The Consumer Affairs Unit regularly refers individuals to the Office of the Health Care Advocate for the excellent and comprehensive assistance they give to individuals pursuing claim appeals.

Table 3 - CID Referrals to OHA

2013 (Through 12/1)	138
2012	174
2011	238

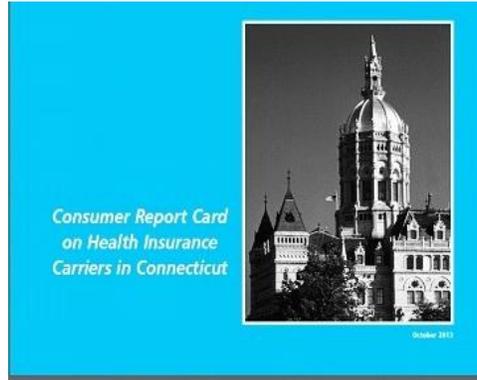
The volume of referrals from the Consumer Affairs unit to OHA has trended downward somewhat since enactment of the Third Party Administrator (TPA) law effective October 1, 2011. Since enactment of this law, the Consumer Affairs Unit has been able to receive responses from TPAs and help consumers covered under self-insured plans with claims administered by TPAs. However, CID continues to value OHA as an additional resource to help consumers, primarily in preparing appeals.

Identifying Troubling Trends or Concerns

Consumer complaints to the Consumer Affairs Unit serve as a very important first indicator of problems in the marketplace. Insurance examiners are trained in insurance statutes and regulations and are vigilant in ensuring that the insurance companies comply with these requirements when reviewing consumer complaints. In investigating complaints, the Consumer Affairs Unit can quickly spot any trends or areas of concern and escalate them rapidly to the Insurance Department’s Market Conduct division. The Market Conduct division will work the issues through to a regulatory conclusion.

The Department strongly urges Committee members and other legislators to refer their constituents with commercial insurance issues to the Consumer Affairs Unit. Complaints and inquiries received better equip the Consumer Affairs Unit to spot trends that need further and global review. In addition, the Consumer Affairs Unit provides assistance to each individual consumer on his or her specific complaint.

4) Consumer Report Card (Appendix F)



The CID's annual [Consumer Report Card on Health Insurance Carriers](#) has a section devoted to mental health. The carriers file data for the prior calendar year by July 1st of the following year and that information is compiled into a report card that consumers can use when selecting a health insurer. The behavioral health data is tracked and compiled separately from medical data and is **on pages 32-41 in the 2013 Report Card**. This information can help consumers with a significant interest and concern about behavioral health benefits and how carriers compare.

5) Market Conduct Division

The Market Conduct (MC) division performs key functions for CID in monitoring compliance. The Market Conduct Division:

- Works closely with the Consumer Affairs Unit to spot trends in consumer complaints and investigates possible violators through examinations and or investigations.
- Uses the Report Card as one of many indicators to identify trends that serve as a basis for more comprehensive reviews. The Department agrees, as noted in Public Act 13-3, that further use of the Consumer Report Card can be an effective additional tool for ensuring compliance
- Is issuing a Bulletin (*Appendix K*) requiring all health carriers to provide specific data to certify and demonstrate compliance with mental health parity requirements. Thereafter, as part of MC's on-site comprehensive examinations, each carrier's data will be reviewed for compliance. The Department will conduct examinations and data calls with objectivity and within the parameters of the law.

By way of example, MC intervened when the CID received complaints in April 2013 from behavioral health providers over reimbursement issues with Connecticut's largest health carrier. As a result of the CID's involvement, the carrier adjusted its medical billing code and reprocessed nearly 40,000 claims. MC monitored the process and received timely updates from the carrier until all providers were made whole by August 2013. A summary of the adjustments follows:

Table 3 – Health Carrier Reimbursement Adjustment

Anthem Adjustment	Providers Affected	Claims	Financial Impact
August 2013 Summary	812	38,059	\$472,795

Data Gathering is Crucial To CID Mission

CID upholds its responsibility to act on trends supported by empirical data and not on anecdotal evidence. Having access to OHA complaint data would enhance CID oversight, as recommended in the past by Program Review & Investigations Committee. The CID has frequently requested OHA files of commercial insurance policyholder complaints to help the Market Conduct Division expedite its examinations of carriers with fuller data.

2013 Department Initiatives & Oversight

- The Commissioner and Deputy Commissioner visited with many members of the State’s federal delegation, last May, in Washington to push for the quick publication of the final mental health parity regulations
- Following review of carriers’ mental health treatment denial letters, the Department strongly requested revision of tone and content of such letters.
- CID distributed the Partnership for Workplace Mental Health “Employer’s Guide for Compliance with the Mental Health Parity and Addiction Act” to the carriers and to Commissioner Rehmer for education and input
- CID developed the “Consumer Toolkit for Navigating Behavioral Health and Substance Abuse Care Through Your Health Insurance Plan” - in order to better prepare families for what they need to know about seeking approval from their insurance company for behavioral health services.
- The Deputy Commissioner of the Insurance Department and the Commissioner of the Department of Mental Health and Addiction Services wrote to the Sandy Hook Commission in the summer of 2013 regarding defining and clarifying the rules for Non Quantitative Treatment Limitation (NQTLs) under mental health parity laws
- CID revised “A Consumer’s Guide to Appealing Health Insurance Denials” – This revised guide informs consumers regarding appealing claims denials and their right to an independent external review through the CID External Review Program
- CID launched a [Mental Health Parity page](#) (*Appendix G*) section on CID Web site

Cross Agency Collaboration/Task Forces

- Collaboration with Department of Mental Health and Addiction Services (DMHAS) for best practices and mutual education
- Consultation with the Department of Psychiatry at the University of Connecticut Health Center
- CID is beginning joint efforts with the Department of Public Health on mental health care provider issues
- CID Staff participation on numerous task forces related to health care generally and mental health parity in particular :
 - ✓ Behavioral Health Task Force for Young Persons
 - ✓ Birth –Three Coordinating Council
 - ✓ Board of Access Health CT (Committees: Human Resources, Finance, Strategy)
 - ✓ Access Health CT Advisory Committees (all 4)
 - ✓ Health Care Cabinet
 - ✓ Health Care Cost Containment Committee (through Office of State Comptroller)
 - ✓ Family Medical Leave Insurance Task Force

Public Comments (Appendices H, I, J, L)

- On September 12, the Department posted public notice (*Appendix H*) pursuant to Public Act 13-3 that solicited written comments related to the methods the Department might use to check for compliance with state and federal mental health parity laws by health insurance companies and others under its jurisdiction.
- In addition to the public notice on its Web site, the Department issued a press release (*Appendix I*) that was distributed to state and national media, both print, broadcast and web-based entities and included links to the comment section on its Web site.
- The Department further publicized the opportunity to comment through its social media channels – Facebook, Twitter and LinkedIn.
- CID reached out directly to the advocate community to solicit comments (*Appendix J*), sending requests by mail or email to the Healthcare Advocate and more than a dozen other individuals representing constituencies in Connecticut and the nation. Their comments were among those received during the public comment period, which was open from September 12 through October 15 – four days longer than the 30-day period provided for in the law.
- In all, the Department received comments from nine individuals and/or organizations (*Appendix K*). One comment was not timely received but was accepted and is included. Much of the input was specific to individual cases which would have been pursued by the Consumer Affairs Unit.

Conclusion

The CID's role is to oversee the full range of activities of the insurance industry in Connecticut. Addressed here, is the oversight of insurance company compliance, not the delivery of mental health care. For those very important situations of individual case management, there is the Childcare Advocate and the Office of the Healthcare Advocate. The roles are clearly distinct. Within the respective roles, The Insurance Department and OHA can and do complement one another. The OHA is an effective patient advocate in helping overturn medical necessity denials because of that office's ability to compile a comprehensive set of records from the provider to present to the carrier.

Because the Insurance Department does not regulate providers, it is grateful to have the opportunity to share this report with members of the Public Health Committee. The CID does believe providers should be more proactive in helping their patients obtain reimbursement for treatment— especially at a time when families are under stress and upheaval. That is why the CID created the Behavioral Health Toolkit – to help walk families through the process. But it can and should be easier for patients if their mental health professional provided the necessary documentation in a reasonable amount of time. Perhaps it's a matter of providers gaining a better understanding of what is needed by the carriers and when. Since health care professionals must obtain continuing education on a variety of subjects for their licenses issued by the Department of Public Health, The CID has suggested offering a course that covers insurance reimbursement. The carriers frequently need more information from mental health providers before pre-authorizing services. CID is happy to work with the carriers and DPH to address this issue and has begun discussion with the DPH Commissioner to facilitate common goals.

There has been a suggestion of the creation of an oversight council of CID to focus specifically on mental and behavioral health compliance. The CID respectfully believes this is unnecessary and unwarranted. The Commissioner serves at the pleasure of the Governor and can be replaced if he or she is not performing appropriately and enforcing applicable laws. The Legislature oversees CID in a variety of ways, including its committee of cognizance, the Insurance and Real Estate Committee, as well as with insurance legislation. Further, CID participates actively in the National Association of Insurance Commissioners and has access to best practices nationally on all areas of insurance regulation.

The CID will continue to vigorously enforce mental health parity regulations with the full scope and regulatory power afforded solely to the Connecticut Insurance Department. It trusts that this report of the robust and routine process of its regulatory oversight of mental and behavioral health compliance by the commercial carriers is informative.



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Appendix A

Mental Health Parity Laws

State Laws: Conn. General Statutes 38a-488a and 38a-514

Sec. 38a-488a. Mandatory coverage for the diagnosis and treatment of mental or nervous conditions. Exceptions. Benefits payable re type of provider or facility. State's claim against proceeds. (a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for the diagnosis and treatment of mental or nervous conditions. For the purposes of this section, "mental or nervous conditions" means mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". "Mental or nervous conditions" does not include (1) mental retardation, (2) learning disorders, (3) motor skills disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

(b) No such policy shall establish any terms, conditions or benefits that place a greater financial burden on an insured for access to diagnosis or treatment of mental or nervous conditions than for diagnosis or treatment of medical, surgical or other physical health conditions.

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

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

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

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

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

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

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

(6) A licensed professional counselor.

(e) For purposes of this section, the term "covered expenses" means the usual, customary and reasonable charges for treatment deemed necessary under generally accepted medical standards, except that in the case of a managed care plan, as defined in section 38a-478, "covered expenses" means the payments agreed upon in the contract between a managed care organization, as defined in section 38a-478, and a provider, as defined in section 38a-478.

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

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

(g) In the case of benefits payable for the service of a licensed physician practicing as a psychiatrist or a licensed psychologist, under subsection (d) of this section, such benefits shall be payable for outpatient services rendered (1) in a nonprofit community mental health center, as

defined by the Department of Mental Health and Addiction Services, in a nonprofit licensed adult psychiatric clinic operated by an accredited hospital or in a residential treatment facility; (2) under the supervision of a licensed physician practicing as a psychiatrist, a licensed psychologist, a licensed marital and family therapist, a licensed clinical social worker, a licensed or certified alcohol and drug counselor or a licensed professional counselor who is eligible for reimbursement under subdivisions (1) to (6), inclusive, of subsection (d) of this section; and (3) within the scope of the license issued to the center or clinic by the Department of Public Health or to the residential treatment facility by the Department of Children and Families.

(h) Except in the case of emergency services or in the case of services for which an individual has been referred by a physician affiliated with a health care center, nothing in this section shall be construed to require a health care center to provide benefits under this section through facilities that are not affiliated with the health care center.

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

38a-514: (Formerly Sec. 38-174d). Mandatory coverage for the diagnosis and treatment of mental or nervous conditions. Exceptions. Benefits payable re type of provider or facility. State's claim against proceeds.

(a) Except as provided in subsection (j) of this section, each group health insurance policy, providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for the diagnosis and treatment of mental or nervous conditions. For the purposes of this section, "mental or nervous conditions" means mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". "Mental or nervous conditions" does not include (1) mental retardation, (2) learning disorders, (3) motor skills disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

(b) No such group policy shall establish any terms, conditions or benefits that place a greater financial burden on an insured for access to diagnosis or treatment of mental or nervous conditions than for diagnosis or treatment of medical, surgical or other physical health conditions.

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

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

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

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

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

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

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

(6) A licensed professional counselor.

(e) For purposes of this section, the term "covered expenses" means the usual, customary and reasonable charges for treatment deemed necessary under generally accepted medical standards, except that in the case of a managed care plan, as defined in section 38a-478, "covered expenses" means the payments agreed upon in the contract between a managed care organization, as defined in section 38a-478, and a provider, as defined in section 38a-478.

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

(2) In the case of benefits payable for the services of a licensed psychologist under subsection (d) of this section, such benefits shall be payable for (A) services rendered in a child guidance

clinic or residential treatment facility by a person with a master's degree in social work or by a person with a master's degree in marriage and family therapy under the supervision of such licensed psychologist, licensed marital and family therapist or licensed clinical social worker who is eligible for reimbursement under subdivisions (1) to (4), inclusive, of subsection (d) of this section; (B) services rendered in a residential treatment facility by a licensed or certified alcohol and drug counselor who is eligible for reimbursement under subdivision (5) of subsection (d) of this section; or (C) services rendered in a residential treatment facility by a licensed professional counselor who is eligible for reimbursement under subdivision (6) of subsection (d) of this section.

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

(h) Except in the case of emergency services or in the case of services for which an individual has been referred by a physician affiliated with a health care center, nothing in this section shall be construed to require a health care center to provide benefits under this section through facilities that are not affiliated with the health care center.

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

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

(k) In the case of benefits based upon confinement in a residential treatment facility, such benefits shall be payable in situations in which the insured has a serious mental or nervous condition that substantially impairs the insured's thoughts, perception of reality, emotional process or judgment or grossly impairs the behavior of the insured, and, upon an assessment of the insured by a physician, psychiatrist, psychologist or clinical social worker, cannot

appropriately, safely or effectively be treated in an acute care, partial hospitalization, intensive outpatient or outpatient setting.

(l) The services rendered for which benefits are to be paid for confinement in a residential treatment facility shall be based on an individual treatment plan. For purposes of this section, the term “individual treatment plan” means a treatment plan prescribed by a physician with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

U.S. Department of Labor

MHPAEA, which amended the Public Health Service Act, the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code, generally is effective for plan years beginning on or after October 3, 2009. For calendar year plans, the effective date is January 1, 2010. The Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury will publish in the Federal Register an interim final rule implementing the provisions of MHPAEA on February 2, 2010. The regulation is effective on April 5, 2010, and applicable to plan years beginning on or after July 1, 2010.

Background

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

MHPAEA applies to plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully insured arrangements. MHPAEA also applies to health insurance issuers who sell coverage to employers with more than 50 employees.

The DOL and the IRS generally have enforcement authority over private sector employment-based plans that are subject to ERISA. HHS has direct enforcement authority with respect to self-funded non-Federal governmental plans. While State insurance commissioners have primary authority over issuers in the large group market, HHS has secondary enforcement authority.

MHPAEA supplements prior provisions under the Mental Health Parity Act of 1996 (MHPA), which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. DOL, HHS and Treasury issued regulations under MHPA in 1997. The MHPAEA interim final rule amends and modifies certain provisions in the MHPA regulations.

Although MHPAEA provides significant new protections to participants in group health plans, it is important to note that MHPAEA does not mandate that a plan provide MH/SUD benefits. Rather, if a plan provides medical/surgical and MH/SUD benefits, it must comply with the MHPAEA's parity provisions. Also, MHPAEA does not apply to issuers who sell health insurance policies to employers with 50 or fewer employees or who sell health insurance policies to individuals.

MHPAEA Continues and Expands MHPA

As noted above, MHPA required parity with respect to aggregate lifetime and annual dollar limits. However, MHPA did not apply to substance use disorder benefits. MHPAEA continued the MHPA parity rules as to limits for mental health benefits, and amended them to extend to substance use disorder benefits.

Therefore, plans and issuers that offer substance use disorder benefits subject to aggregate lifetime and annual dollar limits must comply with the MHPAEA's parity provisions.

The regulations demonstrate how the expanded rules apply, and update certain defined terms and examples as necessary.

Additional MHPAEA Protections Relating to Financial Requirements

Under MHPAEA, if a plan or issuer that offers medical/surgical and MH/SUD benefits imposes "financial requirements" (such as deductibles, copayments, coinsurance and out of pocket limitations), the financial requirements applicable to MH/SUD benefits can be no more restrictive than the "predominant" financial requirements applied to "substantially all" medical/surgical benefits.

The regulations provide that the "predominant/substantially all" test applies to six classifications of benefits on a classification-by-classification basis. The regulation also includes other rules and definitions that are necessary in order for plans, issuers and their advisers to apply this general parity test.

Additional MHPAEA Protections Relating to Treatment Limitations

MHPAEA also provides similar protections for treatment limitations. "Treatment limitations" mean limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

The regulation clarifies that there may be both quantitative and non-quantitative treatment limitations, and provides rules for each. Since they are similar to financial requirements, quantitative treatment limitations are subject to the same general test as the financial requirements discussed above.

Because non-quantitative treatment limitations (such as medical management standards, formulary design, and determination of usual/customary/reasonable amounts) apply differently, the regulation includes a separate parity requirement for them.

Parity with Respect to Out of Network Benefits

If a plan or issuer that offers medical/surgical benefits on an out-of-network basis also offers MH/SUD benefits, it must offer the MH/SUD benefits on an out-of-network basis as well.

MHPAEA Availability of Plan Information Requirements

MHPAEA requires that plans make certain information available with respect to MH/SUD benefits. First, the criteria for medical necessity determinations with respect to MH/SUD benefits must be made available to any current or potential participant, beneficiary, or contracting provider upon request.

MHPAEA also provides that the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits must be made available, upon request or as otherwise required, to the participant or beneficiary.

The regulation clarifies that, for non-Federal governmental plans (which are not subject to ERISA), and health insurance coverage offered in connection with such plans, compliance with the form and manner of the ERISA claims procedure regulations for group health plans satisfies this disclosure requirement.

Exemptions from MHPAEA

MHPAEA retains the exemption for small employers contained in MHPA. MHPAEA modified the exemption contained in MHPA based on increased cost in several respects, which are explained in the statute.

The MHPAEA regulation updates the small employer exemption, withdraws the MHPA regulations concerning the increased cost exemption, and reserves paragraph (g) for additional future guidance.

Additional Issues

The MHPAEA interim final rule is intended to address the most pressing issues that affect the ability of plans and issuers to comply in the near term. The Departments noted several issues in the preamble, and specifically requested comments on:

- Whether additional examples would be helpful to illustrate the application of the non-quantitative treatment limitation rule to other features of medical management or general plan design;
- Whether and to what extent MHPAEA addresses the “scope of services” or “continuum of care” provided by a group health plan or health insurance coverage;
- What additional clarifications might be helpful to facilitate compliance with the disclosure requirement for medical necessity criteria or denials of MH/SUD benefits; and
- Implementing the new statutory requirements for the increased cost exemption under MHPAEA, as well as information on how many plans expect to use the exemption.

Appendix B

BULLETIN HC- 92

June 19, 2013

TO: ALL INSURANCE COMPANIES, FRATERNAL BENEFIT SOCIETIES, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS AND HEALTH CARE CENTERS THAT DELIVER OR ISSUE INDIVIDUAL AND GROUP HEALTH INSURANCE POLICIES IN CONNECTICUT; ALL UTILIZATION REVIEW ENTITIES LICENSED IN CONNECTICUT

RE: Sections 70-78 of Connecticut Public Act No. 13-3 – Behavioral Health Changes to Utilization Review, Grievance and Appeals

Sections 70-78 of Connecticut Public Act No. 13-3 (the “Act”), effective October 1, 2013, amended multiple provisions of the Connecticut utilization review, grievance and appeal statutes as well as the Consumer Report Card statute relating to behavioral health. This bulletin will identify the new provisions and compliance requirements resulting from these revisions.

NEW STATUTORY REQUIREMENTS

The Act has revised the utilization review, grievance and appeals statutes as follows with respect to behavioral health and substance abuse disorders:

- Section 72 amends section 38a-591c of the Connecticut General Statutes and requires that for any utilization review or benefit determination for treating a substance use disorder, the default criteria are those in the most recent edition of the American Society of Addiction Medicine's Patient Placement Criteria. For any utilization review or benefit determination for treating a mental disorder in a child or adolescent, the default criteria are the most recent guidelines in the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument. For any utilization review or benefit determination for treating a mental disorder in an adult, the default criteria are the most recent (1) guidelines of the American Psychiatric Association or (2) standards and guidelines of the Association of Ambulatory Behavioral Healthcare.

In each case, the carrier can use other criteria that it demonstrates are consistent with the default criteria. But if the carrier does this, it must create and maintain a document on an easily accessible location on its website that compares each aspect of its criteria with the default criteria and provides citations to (a) peer-reviewed medical literature generally recognized by the relevant medical community or (b) professional society guidelines that justify each deviation from the default criteria.

- Sections 71 (Conn. Gen. Stat. §38a-591a) and 73 (Conn. Gen. Stat. §38a-591d) require insurance carriers and health care centers to make a determination on a

pre-authorization or concurrent request for specified behavioral health services within 24 hours after receiving the urgent request unless the covered person or his /her representative fails to provide the required information needed to make a determination. The specified behavioral health services that require 24 hour urgent care determinations have been defined as those for a service or treatment for (1) substance use disorder or co-occurring mental disorder and (2) inpatient services, partial hospitalization, residential treatment, or intensive outpatient services needed to keep a covered person from requiring an inpatient setting in connection with a mental disorder.

- The prior law has required that each carrier must promptly notify a covered person and, if applicable, his or her authorized representative, of an adverse determination. The Act additionally requires the notice to list, upon request, any clinical review criteria (including professional criteria) and medical or scientific evidence used to reach a denial. The notice must also describe the carrier's internal grievance procedures. The Act requires the notice to include a statement that, if the covered person or his or her representative choose to grieve an adverse determination, that (1) such appeals sometimes succeed; (2) the covered person or his or her representative may benefit from free assistance from the department's consumer affairs division or the Office of Healthcare Advocate (“OHA”), which can help with a grievance; (3) the covered person or representative is entitled and encouraged to submit supporting documentation for the carrier to consider during the review of an adverse determination, including their narratives and letters and treatment notes from the covered person's health care professional; and, (4) the covered person or representative has the right to ask his or her health care professional for these letters and treatment notes.

If an adverse determination is based on a carrier's internal rule or other similar criterion, the notice must provide the criterion and related information or a statement that a specific criterion was relied upon to make the adverse determination and the criterion is available free of charge upon request. The Act additionally requires the notice to provide the links to the criterion on the carrier's web site. If the adverse determination involves treating a substance use or a mental disorder, the Act requires the notice to also include a link to the carrier's applicable clinical review criteria, as described above, on its website.

- The Act allows a carrier to offer a covered person's health care professional an opportunity to confer with a clinical peer of the carrier under certain circumstances. This provision applies after a covered person or his or her representative or health care professional is notified of an initial adverse determination of a concurrent or prospective utilization review or of a benefit request that was based, at least in part, on medical necessity and if the covered person, representative, or health care professional has not already filed a grievance of the initial adverse determination. The peer to peer conference is not considered a grievance of the initial adverse determination.

- The Act requires if a non-urgent grievance appeal is a concurrent review request, the treatment must be continued without liability to the covered person during the pendency of the grievance of an adverse determination or a final adverse determination of the concurrent review. The law already provides that in the case of grievance appeals filed for urgent requests, treatment must be continued without liability to the covered person during the review.

- Sections 74 (Conn. Gen. Stat. §38a-591e) and 76 (Conn. Gen. Stat. §38a-591g) deal with expedited reviews. By classifying requests for the identified services and treatments as urgent, the amended law entitles the covered person to an expedited review of an adverse determination or an expedited external review and requires that decisions for expedited reviews of requests for services and treatment for the mental and substance use disorders within 24 hours.

- Section 75 (Conn. Gen. Stat. §38a-591f) adds additional requirements to the notice of a decision upholding an adverse determination not based on medical necessity. The Act requires that the notice of the decision must include a statement advising of the covered person's right to contact the Insurance Commissioner's ("Commissioner") office or the OHA at any time; that the covered person may benefit from free assistance from the Insurance Department's ("Department") Consumer Affairs Division or OHA, which can help him or her file a grievance; and the contact information for the offices.

- The Act provides a new definition of clinical peer and requires clinical peers be used for all pre-authorizations or concurrent reviews, reviews of adverse determinations and external review determinations. The Act requires certain clinical peers to have additional qualifications. Under current law, clinical peers are health care professionals who hold a non-restricted license in any state in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review. For a review or benefit determination concerning a substance use or mental disorder in a child or adolescent, the clinical peer must (1) hold a national board certification in child and adolescent psychiatry or child and adolescent psychology and (2) have training or clinical experience in treating child and adolescent substance use or mental disorder, as applicable. For a review or benefit determination concerning substance use disorder or mental disorder in an adult, the clinical peer must (1) hold a national board certification in psychiatry or psychology, and (2) have training or clinical experience in the treatment of adult substance use or mental disorders, as applicable. The Act requires that each carrier have procedures to ensure that the appropriate or required clinical peers are designated to conduct utilization reviews. (See Conn. Gen. Stat. §§38a-591a, 591c, and 38a-591e)

In addition to the amended utilization review, grievance and appeal laws, Section 78 of the Act also amended Conn. Gen. Stat. §38a-478*l*, the statute dealing with the Consumer Report Card. By law, the Commissioner must prepare an annual Consumer Report Card that, among other things, addresses managed care organizations and mental health services. The Act requires the Commissioner to annually analyze this data for the accuracy of, trends in, and statistically significant differences in, the data among the health care centers and health insurers included in the report card. It allows him to investigate such differences to determine whether he should take further action.

Section 79 of the Act, effective upon passage of the Act, establishes new requirements relating to the oversight of federal and state mental health parity compliance by insurers. The Act requires that by September 15, 2013, the Commissioner must seek input from stakeholders on methods the Department might use to check for compliance with state and federal mental health parity laws by health insurance companies and other entities under its jurisdiction. The stakeholders must at least include the OHA, health insurance companies, health care professionals, and behavioral health advocacy groups. The Department also must post notice of the request for input on its web site and provide for a written public comment period of 30 days following the

posting. The posting must include the date the public comment period closes and information on how to submit comments to the department.

Section 79 also requires that by January 1, 2014, the Commissioner must issue a report and provide an educational presentation to the Insurance and Real Estate and Public Health committees. The report and presentation must:

- cover the methodology the Department is using to check for compliance with the interim or final regulations or guidance, whichever is in effect, published by the U. S. Department of Health and Human Services relating to the compliance and oversight requirements of federal law on mental health parity;
- cover the methodology the Department is using to check for compliance with state law on mental health parity; and
- detail the Department's regulatory and educational approaches relating to the financing of mental health services in this state.
- In addition, the report must describe and address any public comments the department received in the comment period described above.

By February 1, 2014, the Insurance and Public Health committees must hold a joint public hearing on the report submitted by the Department.

NEW PROCEDURAL REQUIREMENTS

1. Utilization Review Licensing:

As a result of the Act, filing requirements will change for Utilization Review licenses which are due October 1. All new or renewal applications will need to reflect the revisions identified above both for procedural updates as well as communication materials. The Department will no longer approve national letter templates to be used for review determination notification. Because of the requirements of the Connecticut laws, and the potential for confusion when notification is made on a letter that requires the recipient to determine which state rules apply and ascertain if their plan is fully insured or self-funded, the Department has determined that a Connecticut specific letter, for use only with fully insured plans, will need to be developed by each utilization review company. This letter will need to address all the requirements as provided in the revised statutes. A separate letter can be used for self-funded plans and the self-funded letter is not required to be submitted to the Insurance Department.

Additionally, the applications will need to either state that the entity's review criteria meets the statutory source requirements as provided in the amended Conn. Gen. Stat. §38a-591c for substance abuse and child and adolescent mental health guidelines. If the entity chooses to use alternate criteria, it must provide a link to its webpage where it has posted the document mandated in the amended Conn. Gen. Stat. §38a-591c that compares each aspect of its criteria with the default criteria and provides citations to (a) peer-reviewed medical literature generally recognized by the relevant medical community or (b) professional society guidelines that justify each deviation from the default criteria.

2. Form Filing Policy

Policy forms affected by the statutory changes will need to be re-filed to reflect the new requirements and definitions.

3. Mental Health Parity Form Filing Certification

Effective immediately, every applicable health insurance policy form filing for use in Connecticut sited health insurance contracts subject to the requirements of 42 U.S.C. § 300gg-26, 45 CFR §146.136 and Conn. Gen. Stat. §§38a-488a and 38a-514 will be required to be submitted with a certification verifying that the form is compliant with state and federal mental health parity requirements. This will be submitted through SERFF using the “Supporting Documentation” field.

The Department is requesting that each insurer/health care center file an initial certification for forms already submitted for policies effective January 1, 2014 or later; thereafter, each applicable policy form filing will be required to be accompanied by the certification.

The following is the required language to be used for the certification:

MENTAL HEALTH CERTIFICATION

The undersigned deposes and says that all policy forms submitted (Date) by (Name of Insurer) for use in Connecticut sited health insurance contracts subject to the requirements of 42 U.S.C. § 300gg-26, 45 CFR §146.136 and Conn. Gen. Stat. §§38a-488a and 38a-514 provide coverage for parity in mental health and substance abuse disorder benefits in accordance with both state and federal laws as applicable. The undersigned certifies that all such policies issued or renewed will provide coverage for the medical treatment of mental illness and substance abuse provided under the same terms and conditions as coverage that is provided for other illnesses and diseases in connection with financial requirements, quantitative treatment limitations, prescription drug benefits, and non-quantitative treatment limitations.

(Name) certifies that (s)he is the (Title) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

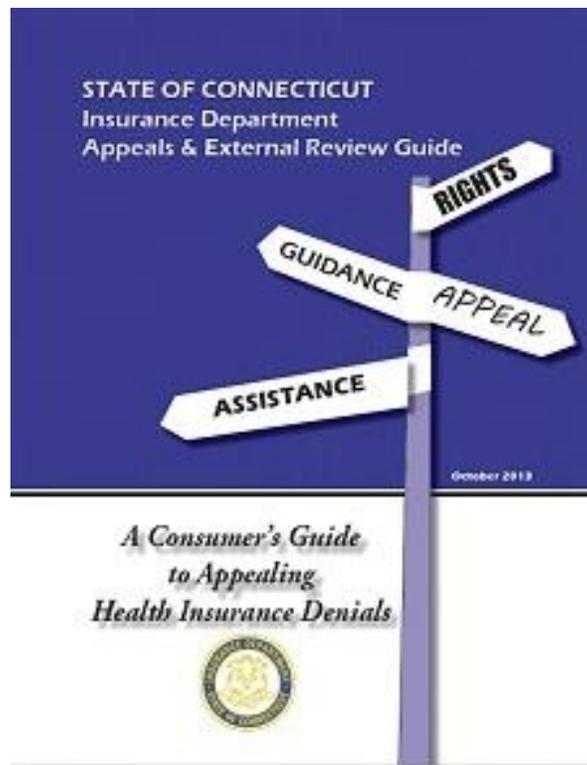
(Date) _____

4. External Review Application and External Review Consumer Guide The Department will make available an updated Request for External Review Application and External Review Consumer Guide for use by the insurance carriers and health care centers that conforms to all requirements under Public Act 13-3. These documents will be distributed later this summer under separate Bulletin.

Please contact the Insurance Department Life & Health Division at cid.lh@ct.gov with any utilization review licensing or Consumer Report Card questions. Please contact the Insurance Department Consumer Services Division at externalreview@ct.gov with any utilization review, grievance or appeal questions.

Thomas B. Leonardi
Insurance Commissioner

[Consumers Guide to Appealing Health Insurance Denials](#)



Press Announcements on Mental Health Initiatives

April 9, 2013



STATE OF CONNECTICUT
GOVERNOR DANIEL P. MALLOY

GOV. MALLOY: COLLABORATION WILL HELP FAMILIES ACCESS MENTAL HEALTH TREATMENT

(HARTFORD, CT) – Governor Dannel P. Malloy today announced that a new collaboration between the Connecticut Insurance Department and the UConn Health Center will help families struggling to get mental health treatment paid through their insurance.

“No one should have to overcome mountains of red tape when they are trying to access mental health services,” said Governor Malloy. “This collaboration allows us to leverage the respective expertise of the Insurance Department and the UConn Health Center to put in place a common-sense approach to what can be a profoundly frustrating process. I commend the Insurance Department and the Health Center for their commitment to improving mental health care access for residents.”

The Insurance Department and UConn Health Center are developing a user-friendly ‘claims tool kit’ for policyholders and providers, especially out-of-network providers who operate on cash basis. The goal is to reduce the number of insurance denials by creating a plain-language claims template specific to behavioral health treatment that policyholders and practitioners can submit to insurance companies for reimbursement. It is intended to help them quickly and accurately prepare claims submissions to reflect medical necessity and increase the number of claims approved on initial submissions.

“It’s been the department’s observations that incomplete or incorrect information, coding errors, and other documentation issues are often the cause of claims denials requiring multiple appeals. We don’t want families having to fight to get the care they need,” said Deputy Insurance Commissioner Anne Melissa Dowling, who oversees the Department’s health insurance initiatives.

Scheduled for completion this summer, the claims tool kit is the first in a series of behavioral health projects the Insurance Department and Health Center are undertaking to assist consumers and providers. Work also includes enhancements to education and outreach materials for mental health insurance coverage.

“We are delighted to work with the Insurance Department on this important initiative and to share our world-class psychiatric and clinical expertise,” said Dr. Frank M. Torti, UConn

Health Center Executive Vice President for Health Affairs and Dean of the Medical School. "This project has the potential to improve the quality of life for so many of our families and especially the children."

About 1.8 million Connecticut residents — roughly half of Connecticut's population — have private or employer insurance plans.

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STATE OF CONNECTICUT
GOVERNOR DANIEL P. MALLOY

Oct. 21, 2013

GOV. MALLOY ANNOUNCES MORE RESOURCES FOR FAMILIES IN ACCESSING MENTAL HEALTH SERVICES

(HARTFORD, CT) – Governor Dannel P. Malloy today announced that enhanced state resources to help Connecticut families access mental health treatment include a claims "[tool kit](#)" to streamline insurance reimbursement and additional funds for prevention and early identification programs.

The behavioral health claims "tool kit," a new free resource developed by the Connecticut Insurance Department (CID), the UConn Health Center and health insurance companies, is a step-by-step plain-language template that families and providers can use to submit to insurance companies for preauthorization of medically necessary behavioral health services.

The Governor also announced that the state Department of Mental Health and Addiction Services (DMHAS) is also receiving two grants totaling \$9 million from the Substance Abuse and Mental Health Services Administration to better address the mental health needs of youth in the community and in schools.

"Protecting the well-being of our children and improving the quality of life for their families have been the overarching goals of my administration and the need for these services has become even more evident after the Newtown tragedy. These resources are a clear example of the compassionate collaboration required to achieve these goals," Governor Malloy said. "With the arrival of the Affordable Care Act, more of our citizens will have health insurance and tool kit is another resource they can use in accessing the treatment. The addition of these grants will enable Connecticut to more effectively reach out to young adults who need mental health support and bolster safe school environments."

Insurance Department Deputy Commissioner Anne Melissa Dowling, who oversees the Department's health insurance initiatives, said the "tool kit" is a downloadable document available [on the department's web site](#) and through health insurance carriers. It includes easy-to-follow instructions, a glossary and a checklist for organizing information.

"We developed the 'tool kit' to help families make sound choices and get the right care," Deputy Commissioner Dowling said. "The department sincerely appreciates the assistance and expertise from the UConn Health Center and the thoughtful input from the carriers. The 'tool kit' is the product of a six-month collaboration aimed at providing clarity and an easier path toward accessing mental health treatment."

The state will use the three-year, \$966,660 Early Diversion grant to promote training, consultation and early identification of mental health problems in children and young adults. DMHAS will collaborate with the National Alliance for Mental Illness (NAMI) and law enforcement Crisis Intervention Teams (CITs) to implement the grant. CITs are partnerships between local law enforcement and community behavioral health providers. The CIT's work to link individuals with mental health problems to community services instead of arresting these individuals. NAMI will train CITs across the state, increasing their ability to engage young adults in treatment when needed.

"Young adults are often more difficult to engage and need specialized supports. This grant will enable us to build upon the excellent work of the CIT Teams" DMHAS Commissioner Pat Rehmer said. "Consultation will be made available to CITs 24-hours per day. These funds will enhance our efforts to better serve Connecticut's youth and young adults."

The Safe Schools/Healthy Students award is a four-year, \$8 million grant to be administered by DMHAS in partnership with the State Department of Education (SDE), the State of Connecticut Judicial Branch Court Support Services Division (CSSD), and the Local Education Agencies (LEAs) of Bridgeport, Middletown, and New Britain. Its goal is to create safe and supportive schools and communities for children and adolescents through grade 12. The grant will allow implementation of activities, services and strategies that decrease youth violence and promote healthy development of children and youth.

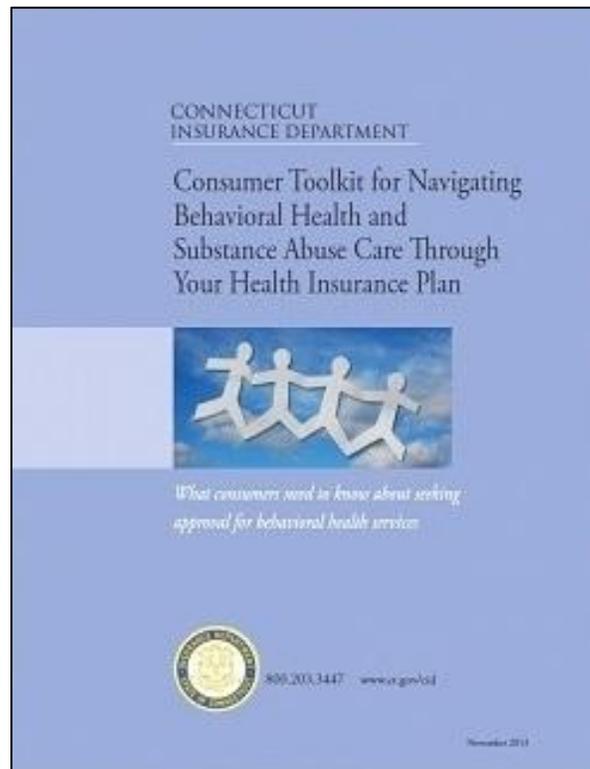
"It has become increasingly clear over the past few years that our schools are a vital partner in creating resilient children and decreasing violence," the Governor said. "State and local partnerships can be a valuable tool in creating and maintaining environments that support a positive school climate that is violence and drug free."

For more information on the claims "tool kit" visit the [CID web site](#)
For more information on DMHAS programs visit the [DMHAS web site](#)

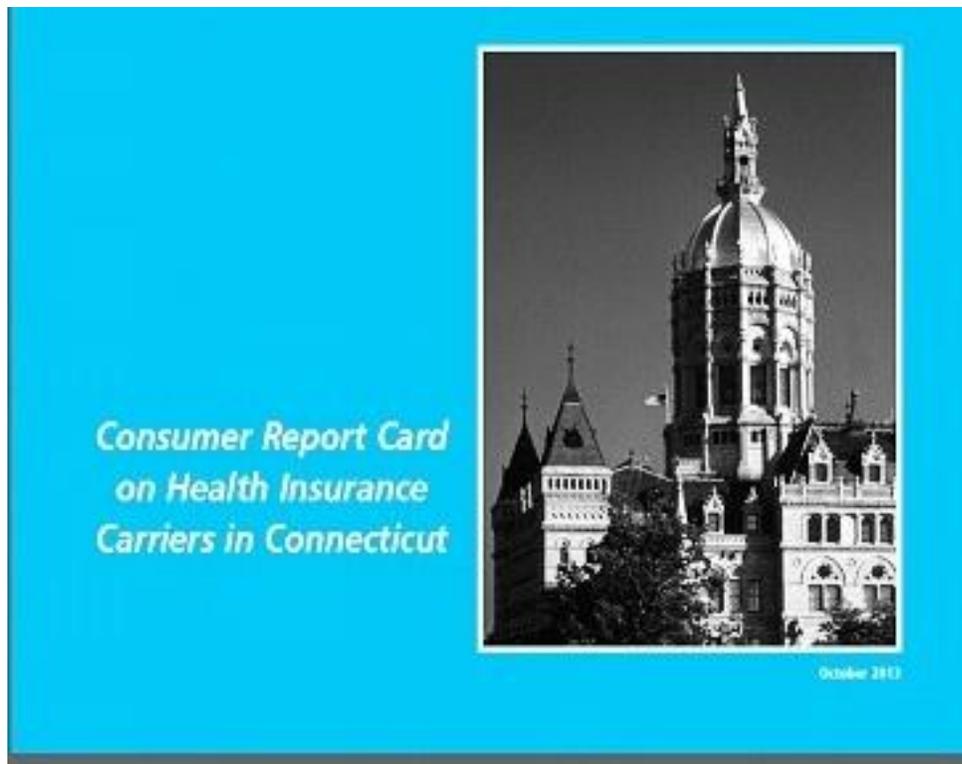
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Appendix E

Consumer Tool Kit For Navigating Behavioral Health and Substance Abuse Care Through Your Health Insurance Plan



[Consumer Report Card on Health Insurance Carriers in CT](#)



Press Announcements on Mental Health Parity Web Page

Dec. 24, 2013



GOV. MALLOY ANNOUNCES NEW INSURANCE WEB PAGE FOR MENTAL HEALTH COVERAGE



(HARTFORD, Conn) – Governor Dannel P. Malloy today announced that a new state Web page streamlines resources to help families with insurance coverage and reimbursement for behavioral health and substance abuse treatment.

The Insurance Department’s [“Mental Health Parity”](#) Web page is a compilation of free resources, publications and tools that consumers can easily access through the [Insurance Department’s Web site](#).

“Our focus remains sharply on removing barriers to mental health treatment and allowing families to get the help and support they need,” Governor Malloy said. “We continue to enhance our mental health infrastructure in a number of ways and this online resource is one more example of that.”

The new site includes the Insurance Department’s [Behavioral Health Tool Kit](#), a step-by-step plain-language template that families and providers can use to submit to insurance companies for preauthorization of medically necessary behavioral health services. The Tool Kit was launched in October, the same time the state announced it was dedicating \$9 million in federal funds to address the needs of children in schools.

Insurance Commissioner Thomas B. Leonardi encourages consumers to visit the new page and take advantage of the resources there that can help them navigate the claims process and gain a better understanding of their rights under state and federal laws.

“Sometimes those barriers to access are piles of insurance paperwork and it doesn’t have to be that way,” Commissioner Leonardi said. “Our staff is here for you – the consumer – to answer your questions, investigate your complaints and get you the care and coverage you need. Each year we help recover more than \$4 million on behalf of Connecticut consumers.”

For more information on the new Web page visit the [CID Web site](#)

Appendix H

Sept. 12, 2013 Notice Soliciting public comment on PA 13-3

STATE OF CONNECTICUT
INSURANCE DEPARTMENT
NOTICE OF REQUEST FOR PUBLIC COMMENT

In accordance with section 79 of Connecticut Public Act No. 13-3, notice is hereby given that the Insurance Commissioner is seeking written comments relating to the methods the Insurance Department (“Department”) might use to check for compliance with state and federal mental health parity laws by health insurance companies and other entities under its jurisdiction. Comments received will be included in a report to be issued not later than January 1, 2014 to the joint standing committees of the General Assembly having cognizance of matters relating to Insurance and Public Health. The report shall cover the methodology the Department is using to check for compliance with mental health parity under state law and also check for compliance with the interim regulations or guidance or the final regulations or guidance, whichever is in effect, published by the United States Department of Health and Human Services relating to the compliance and oversight requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

All interested persons are invited to submit written comments, data, views or arguments within thirty days following the date of publication of this notice on the Connecticut Insurance Department website. Written comments may be submitted in any of the following ways:

1. Electronically: You may submit comments to **CID: Mental Health Parity Comments**

2. Regular Mail: Mail written comments to the following address:

Connecticut Insurance Department
PO Box 816
Hartford, CT 06142-0816
Attn: Mental Health Parity Report

3. Hand delivered, courier, express or overnight mail: Send written comments to:

Connecticut Insurance Department
153 Market Street
7th floor
Hartford, CT 06103
Attn: Mental Health Parity Report

The Department encourages all interested parties to submit comments. For those Connecticut consumers covered through commercial health insurance, the Department seeks to ensure that all such consumers receive benefits to the full extent under the terms of their health insurance policies and under state and federal law. The Department anticipates that the receipt of thoughtful comments will assist the Department in these efforts and also may help in identifying possible legislative changes, if necessary. Copies of the comments received will be available for public inspection during regular business hours at the Insurance Department at 153 Market Street, 7th floor, Hartford, CT 06103.

The Insurance Department does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services or activities, in accordance with Title II of the Americans with Disabilities Act of 1990. Individuals requiring auxiliary aids for communication or other accommodation are invited to make their needs known to Patty Tiberio at (860) 297-3932.
Dated at Hartford, Connecticut this _____12th_____day of September, 2013

Thomas B. Leonardi
Insurance Commissioner

Appendix I

Press Announcement on PA 13-3 Public Comment Solicitation

Sept. 12, 2013

Insurance Department Soliciting Public Comment On Mental Health Parity Compliance

Pursuant to Section 79 of Connecticut Public Act No. 13-3, *An Act Concerning Gun Violence Prevention and Children's Safety*, the Insurance Department has posted a public notice soliciting written comments on methods the Department may use to ensure that health insurance companies are in compliance with state and federal mental health parity laws.

The Department has launched a special Web site to accept [electronic comments](#). Public comment can also be submitted by mail, hand delivered or sent by courier. Details for methods of submission, obtaining copies and other accommodations can be found on the official This is the link to the [public notice](#).

The public comment period runs through October 15. The Department will include the comments in a report it will issue by the end of the year to the Legislature's Insurance & Real Estate and Public Health committees.

All interested parties are urged to submit relevant comments.

###

About the Connecticut Insurance Department: The mission of the Connecticut Insurance Department is to protect consumers through regulation of the industry, outreach, education and advocacy. The Department recovers an average of \$4 million yearly on behalf of consumers and regulates the industry by ensuring carriers adhere to state insurance laws and regulations and are financially solvent to pay claims. The Department's annual budget is

funded through assessments from the insurance industry. Each year, the Department returns an average of \$100 million a year to the state General Fund in license fees, premium taxes, fines and other revenue sources to support various state programs, including childhood immunization.

For help with all your insurance issues:

- Ask a question or file a complaint [online](#)
- Call the Consumer Helpline at **800-203-347** or **860-297-3900**.
- Sign up for [e-alerts](#) to get the latest news, warnings and rate changes that may affect your premium
- Download consumer [FAQs](#) on health, homeowner and auto coverage
- Use the Department's [Speakers Bureau](#) for public events.
- Visit our [Web site](#) and follow the Department on Facebook, Twitter or YouTube

Appendix J

Sept. 13, 2013 Letter to Advocacy Community inviting public comment

Re: Compliance With State and Federal Mental Health Parity Laws

Dear Stakeholder,

In accordance with section 79 of Connecticut Public Act No. 13-3, the Connecticut Insurance Department (CID) is seeking written comments relating to the methods the CID might use to check for compliance with state and federal mental health parity laws by health insurance companies and other entities under the CID's jurisdiction. Attached is a copy of the Public Notice posted on the Department Web site -www.ct.gov/cid -on September 12, 2013.

As stakeholders in the health care, behavioral health, advocate community and insurance, you are personally receiving this invitation to comment because of your expertise in this area. On behalf of the CID, I wanted to ensure that you are apprised of this opportunity. If you are aware of other interested parties with expertise in this area, I urge you to share this with them as well as with your constituents. The CID encourages all parties with relevant comments to submit them pursuant to any of the methods listed on the attachment.

Please note that comments must be received by October 15. Thank you in advance for your review and consideration of this important issue.

Sincerely,

Thomas B. Leonardi Commissioner

Letter recipients:

- Ellen Andrews, Executive Director of the CT Health Policy Project
- Barbara Bunk, Conn. Psychological Association
- Jackie Coleman, Connecticut Psychiatric Society
- Daniela Giordano, National Alliance. on Mental Illness, Conn. Chapter
- Alta Lash, Executive Director of United Connecticut Action for Neighborhoods
- Stephen Karp, National Association of Social Workers, Conn. Chapter
- Kate Matthias, National Alliance. on Mental Illness, Conn. Chapter
- Luis Perez, Mental Health Assoc. of Conn.
- Kate Robinson, lobbyist for Betty Gallo & Co.
- Dr. James Scully, American Psychiatric Association
- Jan Van Tassel, Conn. Legal Rights Project
- Vicki Veltri, State Healthcare Advocate
- Jillian Wood, American Academy of Pediatrics, Conn. Chapter.

Appendix K

Draft Market Conduct Bulletin MC-20

BULLETIN MC-20
JANUARY 2, 2014

TO: ALL INSURANCE COMPANIES, FRATERNAL BENEFIT SOCIETIES,
ASSOCIATIONS, HEALTH CARE CENTERS THAT DELIVER OR ISSUE INDIVIDUAL
AND GROUP HEALTH INSURANCE POLICIES IN CONNECTICUT

RE: MENTAL HEALTH PARITY ANNUAL COMPLIANCE SURVEY

Conn. Gen Stat. §38a-15 authorizes the Insurance Commissioner to undertake a market
conduct examination of the affairs of any insurance company, health care center, or fraternal

benefit society doing business in this state. This bulletin is to announce a new element of the market conduct examination process dealing with mental health parity compliance. Beginning May 1, 2014 and annually by every May 1 thereafter, each insurance company, fraternal benefit society, association, and health care center that delivers or issues individual and group health insurance policies in Connecticut must review its practices and procedures for compliance with state and federal mental health parity requirements and report its compliance status by completing the annual mental health parity compliance survey (a copy of which is attached). If the entity is not in full compliance with all applicable federal and state mental health parity laws, an action plan should be included with the response.

The insurance company, fraternal benefit society, association, and health care center that delivers or issues individual and group health insurance policies in Connecticut must submit a certification to the Department signed by an officer of the company and the chief medical officer that states that the health plan has completed a comprehensive review of the company's practices for the prior calendar year. The survey will be considered incomplete if the certification is not included.

Any insurance company, fraternal benefit society, association, and health care center that delivers or issues individual and group health insurance policies in Connecticut that fails to file the completed survey shall pay a late filing fee of one hundred dollars per day for each day from the date such report was due.

Questions should be directed to the Market Conduct Division at cid.mc@ct.gov.

Thomas B. Leonardi
Insurance Commissioner

Mental Health Parity Annual Compliance Survey Certification

Company: _____

The undersigned certifies that the information that he/she has provided is true and accurate on this _____ day of _____ for and on behalf of _____, that he/she is the _____ of such company, and he/she has authority to execute such instrument.

Signature of Corporate Officer: _____
(Signature)

(Printed Name)

Signature of Chief Medical Officer: _____
(Signature)

Mental Health Parity Annual Compliance Survey

Each insurance company, health care center, fraternal benefit society and association that delivers or issues individual and group health insurance policies in Connecticut (health plan) and its delegated vendors must review their mental health compliance practices for compliance with the provision of state and federal mental health parity requirements, and must provide the Department with a certification that the insurer has completed a complete review of its practices and procedures for the prior calendar year. On or before May 1, 2014 and each subsequent year, each health insurer shall submit information regarding compliance with federal and state mental health parity requirements, including but not limited to the following:

1. Has the plan performed the “substantially all” and predominant level tests with respect to each of the six benefit classifications? Provide an explanation of any differences;

1. Inpatient, In-Network
2. Inpatient, Out-of-Network
3. Outpatient, In-Network
4. Outpatient, Out-of-Network
5. Emergency Care
6. Pharmacy

2. An explanation of any differences in the ways that mental health/substance abuse disorder providers and medical/surgical providers are notified about the health plan’s criteria to determine the medical necessity of the provider’s services;

3. An explanation of any differences in the processes the health plan may require a mental health/substance abuse disorder provider to follow to request authorization for services and/or to provide information that demonstrates the medical necessity of a requested or provided service when compared to the processes the health plan requires for medical/surgical providers and the reasons why the processes may differ;

4. An analysis of the way in which the plan meets federal parity standards if there are any differences between processes, standards and criteria that apply to mental health/substance abuse disorder services when compared to processes, standards and criteria that apply to medical/surgical services;

5. An explanation of any differences in the health plan’s processes used to develop the mental health/substance abuse disorder criteria vs. the processes used to develop medical/surgical criteria that is used to evaluate medical necessity;

6. An explanation of any differences in the standards for granting authorization for out-of-network services between those for mental health/substance abuse disorder services vs. those for medical/surgical services;

7. For each plan offered, a list of any differences in cost-sharing features, penalties and benefit limitations that apply to mental health/substance abuse disorder services that may differ from cost-sharing features, penalties and limitations that apply to medical/surgical services along with an explanation of why the differences may be acceptable;

8. How are fee schedules and reimbursement rates determined for medical/surgical providers as compared to mental health/substance abuse disorder providers?

9. To the extent the health plan is accredited by URAQ or NCQA, please verify the accreditation status and provide proof of accreditation. If NCQA or URAQ standards were not met, provide a copy of the corrective actions to address those concerns; and

10. Provide certification that all policy forms filed in Connecticut are compliant with state and federal mental health parity requirements.

Appendix L

Public Comments

(See Attached PDF)

Cook, Beth

From: hstrain@capitoldecisions.com
Sent: Tuesday, October 15, 2013 1:05 PM
To: Cook, Beth
Subject: Mental Health Parity Comment from: Holly Strain

October 15, 2013

Connecticut Insurance Department
PO Box 816
Hartford, CT 06142-0816
Attn: Mental Health Parity Report

Dear Commissioner:

The Parity Implementation Coalition (PIC) is pleased to submit comments in response to the Notice of Request for Public Comments related to the methods the Connecticut Insurance Department (CID) will use to monitor and enforce compliance with state and federal mental health parity laws by health insurers and other regulated entities. These comments will primarily address the methodologies for monitoring compliance with the federal parity law. The PIC also supports the recommendations included in the Connecticut Coalition led by the State Healthcare Advocate's Office, whose members are directly affected by state and federal parity compliance.

The Parity Implementation Coalition is an alliance of addiction and mental health consumer and provider organizations dedicated to the implementation and enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA). Members include the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine, Betty Ford Center, Cumberland Heights, Faces and Voices of Recovery, Hazelden Foundation, MedPro Billing, Mental Health America, National Alliance on Mental Illness, National Association of Psychiatric Health Systems, National Association of Addiction Treatment Providers, and The Watershed Addiction Treatment Programs, Inc. Many coalition members have Connecticut chapters or affiliates.

PIC members have a significant interest in cooperating with states as implementation and enforcement of MHPAEA moves forward. We have worked cooperatively with the State Healthcare Advocate. Our coalition is willing to continue to provide technical assistance to Connecticut and other states to achieve full implementation of MHPAEA and parity provisions in the Affordable Care Act (ACA).

WITHOUT A FINAL RULE, FULL FEDERAL IMPLEMENTATION AND ENFORCEMENT IS GENERALLY LACKING Without meaningful access to addiction and mental health services, emergency department visits and hospital admissions will remain persistently high and individuals, families and communities in Connecticut affected by mental health and substance use disorders (MH/SUD) will continue to endure needless suffering and unintended consequences. In 2007, 12 million visits made to hospital emergency department (ED) involved individuals with a mental and/or substance use disorder and 35.6% of substance-use related ED visits were billed as uninsured, according to a report (<http://www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf>) from the Agency for Healthcare Research and Quality (AHRQ).

Although the MHPAEA Interim Final Rule (IFR) has been in effect since January 1, 2011, without a promised final rule(<http://www.whitehouse.gov/issues/preventing-gun-violence>), equal access to mental health and substance use services will lag. Coalition members believe the reasons for the lack of compliance are twofold: first, payers legitimately do not want to disseminate compliance guidance only to have to re-issue the guidance when a final rule is

released and, second, significant grey areas in the IFR must be clarified before individuals, families and plans can discern what constitutes MHPAEA compliance. Examples of insurance discrimination that occur regularly today can be found in a report (http://parityispersonal.org/sites/default/files/hearing_report.pdf) summarizing the findings from 11 parity field hearings held around the U.S. in 2012 - 2013, including one in Hartford, that were convened by former Representatives Patrick Kennedy and Jim Ramstad.

MILLIMAN COMPLIANCE AND URAC MHPAEA GUIDANCE ARE IMPORTANT COMPLIANCE TOOLS Milliman has published the Employer's Guide for Compliance with the Mental Health Parity and Addiction Equity Act (<http://www.workplacementalhealth.org/erguide>). This tool is available for use by states and employers.

URAC, one of two health plan accrediting bodies has also released important MHPAEA guidance for plans seeking URAC accreditation. These tools are available at www.parityispersonal.org.

PIC members believe the CID should review and use these tools as the Department proposes to develop a methodology for MHPAEA compliance in Connecticut. Any final report required under Act 13-3 submitted to the General Assembly should include information on the extent to which regulated plans in Connecticut are generally following this recognized compliance guidance and, at a minimum, should report on the extent of compliance with the IFR that has been in effect for nearly three years.

ANNUAL MHPAEA COMPLIANCE AUDITS SHOULD BE CONDUCTED The CID should conduct annual MHPAEA compliance audits and make the results of these audits transparently available on its website. This will drive fidelity to the compliance guidance the state eventually issues and will allow plan participants affected by MH/SUD and the providers who treat them to be more informed about their health plan choices and options.

GREY AREAS MUST BE CLARIFIED

The grey areas in MHPAEA must be clarified in order for any state or federal guidance to be meaningful. PIC organizational members have experienced the need for greater clarity as individuals, families, providers and health plans have worked to implement the law. There is substantial agreement among all stakeholders that these areas must be clarified. PIC members are hopeful that these issues will be clarified in a MHPAEA final rule by the end of 2013; however, the CID should consider clarifying these issues in any MHPAEA guidance or legislation that moves forward in Connecticut to fully implement this law.

DISCLOSURE AND TRANSPARENCY

PIC's consumer and provider organization members have been working on the frontlines of MHPAEA implementation since 2008. Hundreds of complaints have been filed with the Departments of Labor, Department of Health and Human Services' Office of Consumer Information and Insurance Oversight and state insurance commissioners around the country. To our knowledge, only a handful of investigations of complaints have been opened and results are kept confidential. The CID should publicize the results of complaints submitted to CID to deter unlawful business practices and reduce the need to open formal investigations. At the field hearings convened around the country, while there was some promising testimony from some families, patients and providers, the majority of witnesses testified about serious barriers they faced in getting plans to disclose information needed to perform parity compliance audits.

Sub-regulatory guidance issued by the Department of Labor in December of 2010 clarified that plans must not only provide the criteria used to make both behavioral and medical benefit determinations but must also provide an analysis of how these criteria were applied. However, plans continue not to provide an analysis of how criteria is applied used to make medical benefit determinations is applied. Other critical information plans often fail to

provide includes: 1) “proprietary” medical necessity criteria used to make benefit determinations despite MHPAEA’s requirement that medical necessity criteria “be made available upon request to providers and participants” and 2) relevant information about how plans medically manage medical benefits covered under their plan so that consumers can determine if these criteria are applied “comparably and no more stringently” on behavioral benefits.

The CID should clarify in any parity compliance guidance issued to regulated entities that providing medical necessity criteria upon request is the law - regardless of whether the criteria is developed by the plan or an outside vendor. In parity compliance checklists and audits, CID should require an analysis of how medical management criteria are applied to both behavioral and medical benefits. Without this information, it is impossible to assess whether plans are complying with the non-discrimination standard envisioned under the law.

GUIDANCE ON NON-QUANTITATIVE TREATMENT LIMITS IS CRITICAL TO INCREASING ACCESS TO MENTAL HEALTH AND ADDICTION BENEFITS The IFR provided a non-exhaustive list of various types of medical management tools called non-quantitative treatment limitations (NQTLs) in the regulation. The use of NQTLs remains clearly permissible under the IFR, as long as these tools are applied “comparably and no more stringently.” A clear definition of this standard is needed. Without such clarity, access to addiction and mental health benefits is a mere paper promise, just another raised and dashed expectation mental health consumers and providers have faced as parity laws around the country have failed to significantly improve access to care. Often the reasons why state parity laws have not delivered significant improvements in expenditures on MH/SUD are because of the imposition of arbitrary criteria placed on accessing the benefit. Patients and families regularly testified at the field hearings that appeals drag on for years while threatening letters, bills, and indecipherable and ever changing criteria keep coming in the mail - only those with the financial and administrative resources to remain persistent and vigilant have a shot at ever getting their rightful benefits. This complex appeals process is particularly vexing given many patients with these illnesses are too impaired to understand insurance jargon and appeals protocols.

PLANS MUST BE REQUIRED TO OFFER A COMPARABLE CONTINUUM OF CARE TO BE DEEMED MHPAEA COMPLIANT A final MHPAEA rule is expected to address the issue of whether plans must offer a comparable scope of services for medical and behavioral benefits. Any CID-issued methodology to monitor MHPAEA compliance must evaluate whether plans are offering a similar scope and range of medical and behavioral benefits. Without requiring such an analysis, often the most severely ill individuals will not get access to the higher levels of care needed to stabilize and treat severe mental health and addictive disorders. Some have argued that medical and behavioral benefits are too dissimilar for comparisons to be made. A comparative analysis prepared by a worldwide benefits consulting firm Milliman, Inc. showed that there are indeed similarities in the types and range of services offered in the medical and behavioral benefits.

CONCLUSION

The Parity Implementation Coalition applauds the passage of Act 13-3. This groundbreaking law, if properly implemented, has the capacity to vastly improve access to health benefits for those with mental health and addictive disorders in Connecticut. To fully operationalize this law, we stand at the ready to assist the Department as it develops and implements strategies to monitor compliance with MHPAEA and its state parity law.

Please contact Coalition Co-Chairs Sam Muszynski (IMuszynski@psych.org) or Carol McDaid (cmcdaid@capitoldecisions.com) if you have any questions or if we can be of further assistance.

Sincerely,

Irvin L. Muszynski, JD
Co-Chair, Parity Implementation Coalition

Carol McDaid
Co-Chair, Parity Implementation Coalition



By US Mail and Electronic Filing

October 15, 2013

Connecticut Insurance Department
PO Box 816
Hartford, CT 06142-0816
Attn: Mental Health Parity Report

Dear Commissioner:

The undersigned organizations submit the comments herein in response to your Notice of Request for Public Comment relating to the methods the Insurance Department ("Department") might use to check for compliance with state and federal mental health parity laws by health insurance companies and other entities under its jurisdiction.

These comments are provided in a spirit of cooperation and hope for continuing dialog with the Department and stakeholders to achieve the goals of true parity in the prevention and treatment of mental health and substance use disorders.

INTRODUCTION

As a preliminary note, we had hoped that the Department would conduct a stakeholder input process by convening interested stakeholders in an attempt to reach consensus on tools or mechanisms the Department could use to ensure compliance with state and federal parity laws. Public Act 13-3 required a stakeholder engagement process **and** a public comment period. Public Act 13-3, Section 79 (a) provides,

Sec. 79. (Effective from passage) (a) Not later than September 15, 2013, the Insurance Commissioner shall seek input from stakeholders, including, but not limited to, the Healthcare Advocate, health insurance companies, health care professionals and behavioral health advocacy groups on methods the Insurance Department might use to check for compliance with state and federal mental health parity laws by health insurance companies and other entities under its jurisdiction. The department shall also post notice of such request for input on its Internet web site and provide for a written public comment period of thirty days following the posting of such notice. The department shall include in such posting the date the public comment period closes and instructions on how to submit comments to the department.

Although we welcome the opportunity to publicly comment, we believe an opportunity was missed. We also believe that a stakeholder input process would lead to a better result and understanding of state and federal mental health parity laws. Therefore, we strongly recommend that the Department convene such a process once it receives public comment or in the event a final regulation is issued prior to the date the Department report is due to the legislature.

The group of provider and advocacy undersigned stakeholders gathered to forge consensus on the comments included herein¹ to assist the Department in its efforts to ensure compliance with state and federal parity laws.

The need for clarity and transparency on how the Department will enforce state and federal parity laws is greater than ever has been. Enrollment into qualified health plans offered on Access Health CT will add tens of thousands of lives to the memberships of insurers in Connecticut. Tens of thousands of racially and ethnically diverse newly insured individuals and families will gain private insurance coverage.

And because of the Affordable Care Act, for the first time, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) will apply to individual and small business plans in the state.

We present first a summary of recommendations which we believe will lead indirectly to better enforcement of state and federal parity laws.

Summary of Recommendations

MHPAEA Related Process Recommendations

- Propose or support legislation to codify MHPAEA (as amended by the ACA to apply to individual and small group plans) into state law—similar to the provisions of Conn.Gen.Stat. § 38a-591 that incorporate the Affordable Care Act into state law.
- Convene an ongoing and diverse stakeholder² advisory body on mental health parity that meets regularly and openly *or* participate in meetings convened by the Office of the Healthcare Advocate under its authority under Conn.Gen.Stat. § 38a-1041(e)
- Publish the Interim Federal Rule (IFR) (and subsequent final rule) for MHPAEA in a prominent place on the CID website
- Work with stakeholders to push for quicker publication of final regulations on MHPAEA
- When a final MHPAEA rule is published, convene the group above in open and public meetings to attempt to forge consensus on public comment and implementation on that rule

¹ The groups included herein invited CID counsel to attend a stakeholder meeting to discuss input and to try to work together on section 79 of PA 13-3. Counsel declined the invitation to the stakeholder meeting due to the tolling of the public comment period.

² By “stakeholder”, we mean all of the groups listed in section 79(a) of Public Act 13-3. All parties should be at the same table.

- Reconvene the group to discuss the Department's plan for enforcement of that rule
- Issue a bulletin to all carriers and utilization review companies on CID's enforcement of the interim and final federal rules
- Build upon and maintain consumer protections negotiated with carriers in P.A. 13-3

Specific MHPAEA Enforcement Recommendations

- Improve standards in contracting and verify parity in reimbursement methodologies for providers who deliver behavioral health services, either in solo or integrated care practices
- Assure that strategies and credentialing for behavioral health provider networks is consistent with parity requirements
- Review carrier and utilization review company prior authorization and concurrent review processes for behavioral health services to ensure that they are no more burdensome than those on the medical side
- Utilize the Partnership for Workplace Mental Health's "Employer's Guide for Compliance with the Mental Health Parity and Addiction Equity Act"³ as guidance for enforcement of MHPAEA in Connecticut
- Take into account claims in ongoing litigation in CT, VT, NY and CA on violations of non quantitative treatment limitations under the MHPAEA IFR

Publish on the Department's website the result of its analysis of the carrier's or utilization review company's compliance with MHPAEA

Process Improvements on Enforcement of State and Federal Parity Laws

- Adopt transparent and proactive processes for validating carrier criteria rather than relying solely on assurances of the validity of criteria
 - If criteria are found to be invalid, order review of cases decided under that invalid criteria and allow re argument of consumer appeals
- Work with and use the expertise of stakeholder groups that have deep experience in patient and consumer appeals in developing tools to improve access to services
- Given the pervasiveness of health inequities by race/ethnicity in all categories of health, including mental health, we recommend that CID support more concerted efforts to collect racial and ethnic patient demographic data and:

³ The Partnership for Workplace Mental Health is a program of the American Psychiatric Foundation. The employer guide, produced by Milliman, is available at <http://www.workplacementalhealth.org/erguide>.

- Begin to monitor the extent to which mental health parity issues affect consumers of color, as well as compare MHP issues between groups.
- Provide public information geared toward consumers about MHP's meaning and procedures in English in plain language and in the top three non-English languages spoken in the state.
- Include gathering input on equity issues in the stakeholder engagement process that has been requested

Additional Utilization Review Recommendations

- Publish internal and external review success rates as a percentage of behavioral health appeals by level of care. The rates should be published separately from medical appeals and ensure that the statistic reflects the rates of overturned cases are calculated as a percentage of the type of appeal (e.g., BH appeals won /BH appeals filed)
- Revise the external appeals guide to take into account the nature of records needed to support a behavioral health appeal
- Simplify notices from carriers to consumers and providers to explain detailed rationale for denying services

DISCUSSION

Behavioral health parity remains a struggle, and while Connecticut's law with respect to covered benefits is strong, the utilization review process for behavioral health services was less than transparent and failed to recognize the urgency of quick responsiveness on behavioral health requests and appeals. And because the Department admittedly does not have the in-house expertise to render an opinion on the adequacy of plan criteria and how it is/was developed, the need for transparency on criteria used to determine medical necessity in behavioral health cases (and how those criteria are developed) is critical.

Public Act 13-3 Made Significant Improvements in the Utilization Review Process

The provisions adopted in Public Act 13-3 to revise the utilization review process by a) requiring 24 hour turn around on nearly all mental health and substance use (MH/SU) cases, b) tightening of the definition of clinical peer for MH/SU cases, and c) requiring the use of explicit criteria and making those criteria and comparison documents available through a link in a denial notice, were timely and necessary reforms to put CT on a true road to parity. The transparency in criteria requirement was an absolute necessity to achieving equity. (One only has to compare many of the carriers' medical criteria to their behavioral health criteria to see the lack of citations to peer-reviewed literature for behavioral health criteria as compared to medical criteria. Criteria should be readily available. Because carriers now have their criteria online, there can be no argument that the criteria should be shielded from the view of a member via a hyperlink in a member denial notice.)

Importantly, the provisions of PA 13-3 were negotiated in good faith directly with the carriers' representatives. As these provisions just became effective on October 1st, these provisions must be given operational effect. (As the signatories discussed, there is agreement to modify the adult

psychiatric criteria referenced in the Act to agree upon criteria by all stakeholders. The signatories also believe that the current clinical peer definition should reflect that a psychiatrist's true peer is a psychiatrist and a psychologist's true peer is a psychologist.)

The signatories strongly endorse PA 13-3 as a very bold step toward the achievement of parity in Connecticut and would strongly oppose efforts to modify any provisions other than those described directly above. PA 13-3 must be given full effect.

We successfully built upon our existing laws to level the playing field in terms of transparency of decision making on cases and a more robust clinical peer standard. Other states and parity advocates across the country are looking at PA 13-3 as a model to help achieve parity under MHPAEA.

MHPAEA

While PA 13-3 moves us farther on the road toward parity, there is more to do, and we believe that MHPAEA provides the fuel for full parity. MHPAEA builds on the strong laws we have in Connecticut by ensuring that quantitative limitations, such as visit limits and cost sharing, and nonquantitative limitations (NQTLs) as described below, are applied no more stringently to mental health and substance use services than they are to medical services. Connecticut's law does not address certain quantitative limitations. It does not reach non quantitative limitations. MHPAEA, therefore, provides a significant layer of protections above and beyond existing CT law. While a final federal regulation is pending, we believe that the interim federal rule provides very good guidance on non-quantitative treatment limitations. We also believe that guidance and tools developed since provide strong guidance on enforcement.

In trying to achieve parity and enforcement of MHPAEA we work directly with the chief proponents of the MHPAEA. Carol McDaid of the Parity Implementation Coalition and other recovery advocates worked on passage of the MHPAEA at ground level. In CT, we have worked directly with Ms. McDaid and national and local provider and advocacy groups.

The undersigned do not believe that the Department has indicated that it has concerns with enforcing to quantitative financial and treatment limitations (QTLs) of the IFR, including cost sharing, visit limits, lifetime limits, etc. on the six classifications of benefits outlined in the IFR:

1. Inpatient, In-Network;
2. Inpatient, Out-of-Network;
3. Outpatient, In-Network;
4. Outpatient, Out-of-Network;
5. Emergency Care; and
6. Pharmacy

However, we do not have any indication on how the Department is enforcing or will enforce these quantitative treatment limitations under the MHPAEA. We recommend that the Department publish a bulletin or guidance on how it will enforce the QTLs under the MHPAEA. We also recommend that the Department work on guidance for consumers with the stakeholders via an ongoing stakeholder advisory group on MHPAEA to ensure that clear and meaningful messaging about the meaning of parity with respect to both QTLs and NQTLs is distributed across the state.

The signatories believe that the major issues with MHPAEA enforcement here (and elsewhere) centers on non-quantitative limitations (NQTL) as described in the Interim Final Rule (IFR) and lack of clarity on whether plans must provide comparable types and levels of care between behavioral and medical plans. NQTLs include but are not limited to: (A) medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; (B) formulary design for prescription drugs; (C) standards for provider admission to participate in a network, including reimbursement rates; (D) plan methods for determination of usual, customary, and reasonable charges; (E) refusal to pay for higher cost therapies until it can be shown that a lower cost therapy is effective (i.e., fail-first policies or step therapy protocols); and (F) exclusions based on failure to complete a course of treatment. 29 CFR 2590.712(c)(4)(ii).

Specifically, the Department has expressed the concern that it is not sure what the federal rule means by the rule's language that a NQTL cannot be applied more stringently to behavioral health than to medical health unless "clinically appropriate standards permit a difference." The Department has indicated its willingness to take guidance from professionals with medical and behavioral expertise, and the Guide provides such guidance.

The [Employer's Guide for Compliance with the Mental Health Parity and Addiction Equity Act](#) ("The Guide") published by Milliman accounts for and builds on the limited guidance issued thus far, is supported by leading provider organizations and is consistent with the recent decision in a Vermont



c--m--v--fletcher-alle
n-health-care--inc[1].

litigation. See C.M. v. Fletcher Allen Health Care. .

We believe the Guide provides the best analyses and guidance of the MHPAEA IFR (for both QTLs and NQTLs). The Department should use this guidance to develop a bulletin and in its work with a stakeholder advisory group to develop tools for consumers and providers.

To be in compliance with the IFR, health plans must follow this analysis when comparing the provision of medical/surgical benefits and MH/SUD benefits within the same benefits classification. The analysis provides that a covered health plan cannot impose an NQTL with respect to MH/SUD benefits in any classification unless:

- (1) the non-quantitative treatment limitation is comparable to a non-quantitative limitation for medical/surgical benefits; AND
- (2) the non-quantitative treatment limitation is applied no more stringently to the MH/SUD benefits than to the medical/surgical benefits; UNLESS
- (3) there is a recognized clinically appropriate standard of care that permits an exception (i.e., more stringent or non-comparable application) to parts 1 and 2 of the NQTL test above (i.e., a valid exception permits an NQTL which is non-comparable and more stringent).

The Guide at 12.

The Guide provides analysis of the evidence that would be required to show compliance with each of the QTLs and NQTLs. In Connecticut right now, litigation is underway regarding MHPAEA violations of at least three of the NQTLs. Providers are currently raising new issues of NQTL violations concerning the rate setting of psychologists' rates in the qualified health plans sold on Access Health CT. Consumers are part of the class that is litigating violations of parity on medical management.

We strongly endorse the Guide's position that the test of parity that allows more stringent application of NQTLs when "clinically appropriate standards permit a difference" is a test that applies to in an **individual** case and not to all services within a classification. To interpret this phrase otherwise would mean that this exception would swallow the parity rule. We agree with the Parity Implementation Coalition's position (attached) that further definition of "Recognized Clinically Appropriate Standards of Care" must be accounted for in the final MHPAEA rule and in the Department's enforcement of MHPAEA.

We also strongly believe that the final MHPAEA rule will include guidance on requiring comparable types and levels of services between behavioral health and medical services, i.e., a scope of services parity requirement. To achieve real parity, there must be comparability of services. The lack of a requirement of comparable services undermines the purpose of MHPAEA. For instance, when an individual breaks a hip, he or she will likely get inpatient acute care with appropriate time to recover, followed by skilled rehabilitation, outpatient daily rehabilitation, occasional physical therapy and then only outpatient treatment if necessary. On the behavioral health side, plans must be required to offer such a comparable continuum of types and levels of services. A continuum of services does exist on the behavioral health side, but coverage is not as easily attained or recognized by carriers. Although there is no barrier in CT law to such a continuum of care, we believe reinforcement of the requirement to provide such a continuum of services, if medically necessary, is vital to ensure parity under MHPAEA.

Further Recommendations to Ensure Stronger Protections under State Law

Finally, to make our state law more meaningful and to ensure transparency, we recommend that the Department adopt strategies to report to the public how it ensures compliance with 38a-591c. The undersigned organizations represent patients, providers and consumers who have experienced denials of behavioral healthcare coverage and who feel that the process for determining medical necessity is sometimes confusing, hidden and unfair. Therefore, we suggest that the Department:

- Could assure more confidence in its enforcement of state (and federal parity laws) by relying less on assurances from the carriers as to the adequacy of the carriers' criteria, and instead perform routine monitoring of the carriers' criteria—not only behavioral health criteria—to ensure that the criteria are valid and periodically updated.
- Require carriers to notify members and providers if the criteria used for a decision is found to be invalid
- Publicize the list of qualified vendors that the Department has approved and which carriers are using such criteria so interested parties may purchase such criteria
- Publicize methods that the carriers are using to ensure that criteria are being applied consistently

CONCLUSION

We are interested in working together to align stakeholders on MHPAEA enforcement. We welcome the opportunity to discuss our recommendations with you and insurer and utilization review company representatives in an ongoing parity advisory stakeholder group. We look forward to the final federal regulation and pledge to work with the Department to ensure full and fair enforcement of MHPAEA in Connecticut regulated plans.

Thank you for your attention to our recommendations.

Very Truly Yours,



Victoria Veltri
State Healthcare Advocate
Office of the Healthcare Advocate

For herself and

Carol McDaid and Sam Muszynski, Co-Chairs, Parity Implementation Coalition*

Susan C. Campion President
Connecticut Association of Addiction Professionals

Sarah Egan, Acting Child Advocate
Office of the Child Advocate

Jackie Coleman, Executive Director
Connecticut Psychiatric Society, a District Branch of the American Psychiatric Association

Barbara Bunk, President
Connecticut Psychological Association

Stephen Karp, Executive Director
National Association of Social Workers, CT Chapter

Karyl Lee Hall, Staff Attorney
Connecticut Legal Rights Project

Luis Perez, President and CEO
Mental Health Association of Connecticut

Jillian Wood, Executive Director
American Academy of Pediatrics, Connecticut Chapter
Connecticut Council of Adolescent and Child Psychiatry

Kate Mattias, Executive Director
National Alliance on Mental Illness, CT Chapter

* Parity Implementation Coalition (PIC) membership can be viewed at <http://parityispersonal.org/About-Us>

Alice Forrester, Executive Director
Clifford Beers Child Guidance Clinic

Morna Murray, President and CEO
Connecticut Community Providers Association

Patricia Baker, President and CEO
Connecticut Health Foundation

Margo Maine
National Eating Disorders Association

Jan Van Tassel and Abby Anderson, Co-Chairs
Keep the Promise Coalition

Guidance Must be Provided on What Constitutes “Recognized Clinically Appropriate Standards”

In the last part of the NQTL general rule, the regulations permit an exception to the “comparable and no more stringently standards” only “to the extent that recognized clinically appropriate standards of care may permit a difference.”¹ To ensure the strong parity protections envisioned by Congress, the Departments must adopt a definition of “recognized clinically appropriate standards of care” that is based on external, independent and objective clinical policies and standards.

Coalition members are experiencing plans and issuers justifying the imposition of NQTLs based upon their own internal “expert” opinions of what may be considered clinically appropriate. Plans are in fact deeming their own internal opinions on clinical appropriateness to be protected under the regulations. Clearly defining “recognized” as an external, independent and objective factor, is critical to ensuring compliance with the statute and the regulations. As noted, the only exception to the requirements that NQTLs be comparable to and applied no more stringently than is when “recognized clinically appropriate standards of care” permit a difference. Thus, any attempt to bypass the parity requirements will involve finding a “recognized clinically appropriate” standard of care. If adequate requirements are not established to determine when a standard is recognized, the parity requirements will continue to be circumvented. As we have seen, a plan could internally trigger the exceptions simply because its own employees or hired consultants deem a standard “recognized”—with no outside verification.

Such a result opens a loophole that weakens Congress’ intended parity protections. Congress’ purpose in passing the statute was to ensure meaningful parity between MH/SUD and medical/surgical benefits by expanding previously-approved mental health parity legislation. In the statute, Congress was very clear that treatment limitations should be “no more restrictive” in MH/SUD benefits than in medical/surgical benefits. By expanding previous parity legislation, and using clear language in doing so, Congress expressed an intent to ensure strong parity protections. Permitting an exception to parity based on a plan’s internal review alone will weaken, (and is already weakening), the equity between MH/SUD and medical/surgical benefits that Congress sought.

Definition of “Recognized Clinically Appropriate Standards of Care”

To avoid this result, the Departments should clearly define “recognized clinically appropriate standards of care.” This definition should state clearly that any “recognized” standard of care for purposes of the NQTL exceptions test must be: (1) an independent standard that is not developed solely by a single health plan or plans; (2) based on input from multiple stakeholders and experts, such as academic researchers, senior practicing clinicians, and consumer leaders with subject matter expertise in addition to a health plan or its advisory panels; (3) recognized or accepted by multiple nationally recognized provider and consumer organizations and/or nationally recognized accrediting organizations that are responsible for developing quality standards; and (4) based on objective scientific evidence, such as peer-reviewed publications of control group research trials or expert consensus panels.²

¹ 75 Fed. Reg. 5436, 5443, 5450.

² These recommendations are consistent with the manner in which numerous government agencies make scientific and clinical judgments. For example, CMS regularly relies on independent expertise when making its coverage determinations. There is clear precedent for CMS to take a rigorous view of the evidentiary basis for Medicare reimbursement of drugs, devices and procedures. In the National Coverage Determination (NCD) process, CMS

The Coalition fully appreciates that the purpose of having the exception of a “clinically recognized standard” that permits a more stringent application of an NQTL is to leave unencumbered management techniques that improve the quality of patient care and demonstrate better outcomes. A plan’s or insurer’s position that MH/SUD is different from medical/surgical in treatment or diagnosis, does not by itself create a standard that allows more restrictive and/or stringent management, unless it can be objectively demonstrated that the specific NQTL will improve the quality of patient care and outcomes if applied in a more stringent manner. Likewise, showing that a particular NQTL is more effective at cost containment for MH/SUD as compared to medical/surgical does not, by itself, create a clinical standard that allows more restrictive management.

Example 3 under the general rule for NQTLs in the regulations aptly demonstrates this point:

Example 3. (i) Facts. A plan generally covers medically appropriate treatments. For both medical/surgical benefits and mental health and substance use disorder benefits, evidentiary standards used in determining whether a treatment is medically appropriate (such as the number of visits or days of coverage) are based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved. The evidentiary standards are applied in a manner that may differ based on clinically appropriate standards of care for a condition.

(ii) Conclusion. In this *Example 3*, the plan complies with the rules of this paragraph (c)(4) because the nonquantitative treatment limitation – medical appropriateness – is the same for both medical/surgical benefits and mental health and substance use disorder benefits, and the **processes for developing the evidentiary standards and the application of them to mental health and substance use disorder benefits are comparable to and are applied no more stringently than for medical/surgical benefits. This is the result even if, based on clinically appropriate standards of care, the application of the evidentiary standards does not result in similar numbers of visits, days of coverage, or other benefits utilized for mental health conditions or substance use disorders as it does for any particular medical/surgical condition.**” 75 Fed. Reg. 5436, 5443, 5450. (Emphasis supplied).

This *Example 3* from the regulations in regards to the creation of clinically recognized standards demonstrates that when there is parity in how a clinically recognized standard is formulated between medical/surgical and MH/SUD benefits, even if the application of an NQTL results in different outcomes, the NQTL may not be applied in a more stringent manner.

evaluates all pertinent data, including the scientific data that requesters submit, peer-reviewed medical, technical and scientific literature, and recommendations from expert panels. CMS also can order a health technology assessment to provide an independent analysis of all of the scientific and clinical evidence available on a particular health care technology. The Medicare Coverage Advisory Committee (MCAC) also plays a role in assisting the agency in making sound coverage decisions. MCAC provides independent, expert advice based upon the reasonable application of scientific evidence through members who possess the scientific and technical competence to provide these assessments.

Cook, Beth

From: cmbarbieri41@sbcglobal.net
Sent: Thursday, September 19, 2013 9:46 PM
To: Cook, Beth
Subject: Mental Health Parity Comment from: Carolyn M. Barbieri

My son who will be 50 years old in January has been diagnosed as Bi-Polar with Schizoid Tendencies. He has been "different" since he was a little boy. We were always limited by our insurance on the amount of visits he could make to a mental health specialist. We now know that mental disorders are diseases of the brain, much like heart, lung, kidney and cancers are diseases of the body.

It's about time the insurance companies realize that treatment when symptoms first present will save them money in the long run rather than repeated hospitalizations. With the proper treatment and medication, people with all forms of mental illness can learn how to manage their disease and have a chance at a successful life. If my son had received the proper treatment when he was 8 years old, he would not have been hospitalized over 30 times, nor would he have lived on the street, eating out of garbage bins and sleeping on loading platforms.

He is currently in and out of the hospital, single rooms in the most run-down part of town, hungry when his food stamps are stopped because of very strict paperwork rules (most of the time he does not get the paperwork because his address does not remain constant.) A recent statistic quoted by the President of NAMI CT stated that "60% of people with symptoms of mental illness are NOT DIAGNOSED and not in any kind of treatment plan." If 60% of people with heart, lung or cancer disease were not diagnosed nor receiving treatment, there would be a huge outcry from the public. Mental illness crosses all social and economic classes and is found in every country in the world! REMEMBER, MENTAL ILLNESS IS THE RESULT OF CHEMICAL IMBALANCES IN THE BRAIN AND IS NOT ANYONE'S FAULT - THESE PEOPLE DESERVE A CHANCE AT HAVING A PRODUCTIVE LIFE AND SHOULD NOT BE LEFT WANDERING AROUND HOMELESS, SENT TO JAILS OR DISCHARGED OUT OF HOSPITALS AFTER ONLY 72 HOURS!!! THERE ARE ALSO NOT MANY OF THE COMMUNITY RESOURCES THAT WERE PROMISED WHEN MOST OF THE STATE MENTAL HOSPITALS WERE CLOSED! Stop focusing so much on gun control and give the mentally ill places to go for treatment in the community where they will feel safe and not fear being thrown out before they are ready!

Cook, Beth

From: Susanskipp@gmail.com
Sent: Saturday, September 14, 2013 5:43 PM
To: Cook, Beth
Subject: Mental Health Parity Comment from: Susan Skipp

The best way to show you a serious issue is for you to read this. Mental health providers are the middlepeople in the brokering of children that is not limited to family court as this link explains, but is a pervading issue with Dcf.

<http://www.credomobilize.com/petitions/overturn-the-illegal-decision-of-judge-lynda-munro-and-investigate-the-systemic-problem>

Cook, Beth

From: carol.malenfant@ct.gov
Sent: Friday, September 13, 2013 3:28 PM
To: Cook, Beth
Subject: Mental Health Parity Comment from: Carol Malenfant

I believe that insurance companies should allow individuals to do a double session with a therapist on a single day as some therapies take longer than 45 or 60 minutes to administer/perform.

As an individual who is a psychotherapist and who has had psychotherapy I have experienced having to pay cash for therapy since therapists cannot bill two sessions on one day.

Also there are days when I might do a family session and then immediately after do an individual session for the identified patient in the family. Again one of these sessions would have to be paid in cash in keeping with the insurance codes.

Thank you,
Carol Malenfant

Cook, Beth

From: Susanskipp@hotmail.com
Sent: Friday, September 13, 2013 12:35 PM
To: Cook, Beth
Subject: Mental Health Parity Comment from. Susan Skipp

I have documented insurance billing fraud for Sydney Horowitz phd and Howard Krieger Phd of connecticut resource group. Horowitz regularly commits perjury. I will show you transcripts. Both are defending allegations from Connecticut Department of Health of malpractice and negligence. Horowitz triple bills the state. I have reported this several times, no one even wanted to see the documents. I still have them.

Cook, Beth

From: lynn.ereskena.manning@gmail.com
Sent: Friday, September 13, 2013 12:23 PM
To: Cook, Beth
Subject: Mental Health Parity Comment from: Lynn Ereshena-Manning

Good Afternoon,

As a clinical social worker, in private practice, it has frustrated me that I am given 12 or 20 sessions with some insurance plans that my clients carry through their work. Then, in order to continue outpatient treatment I must do an OTR to request more sessions. Is the medical community obligated to this same structure in order to provide treatment and meet their patients needs? This needs to be looked at as an issue for mental health parity.

Thank you.

Lynn Ereshena-Manning LCSW

Cook, Beth

From: gallo@optonline.net
Sent: Friday, September 13, 2013 8:30 AM
To: Cook, Beth
Subject: Mental Health Parity Comment from: Sheila Matthews

Dr. William Glasser clearly points out that when the model proposed in your "Mental Health" parity is used to diagnose a mental illness such as those described in the DSM-IV, one of the basic tenets of the medical model is completely ignored. In those instances, mental illness is diagnosed from symptoms alone and no supportive pathology is required. This misuse of the medical model has led to the present ever-increasing assortment of diagnoses and treatments, none of which even comes close to meeting the requirements of medical science. Reference: Defining Mental Health as a Public Health Issue, A New leadership role for the helping and teaching professions, William Glasser, M.D.

your friends at www.ablechild.org, we oppose this political push by the State



Association for Behavioral
Health and Wellness

*Advancing benefits and services
in mental health, substance use
and behavior change.*

November 7, 2013

Thomas B. Leonardi
Insurance Commissioner
Connecticut Insurance Department
PO Box 816
Hartford, CT 06142-0816

Dear Commissioner Leonardi:

I am writing on behalf of the Association for Behavioral Health and Wellness (ABHW) regarding implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA) in Connecticut. ABHW is the national voice for specialty behavioral health and wellness companies. ABHW member companies provide specialty services to treat mental health, substance use and other behaviors that impact health to nearly 125 million people, approximately two million of whom live in Connecticut. ABHW and its member companies have long been supporters of mental health parity legislation and have been diligently working to implement the interim final rule (IFR) over the last several years.

ABHW, along with many others, is anxiously awaiting the release of the final MHPAEA rule. As you know, President Obama has committed to issuing final MHPAEA regulations this year; and those regulations are currently awaiting approval from the Office of Management and Budget (OMB). ABHW has asked federal regulators to provide more clarity in the final regulations so that our members can better understand what the regulators consider proper implementation of the MHPAEA. While we fully recognize that states have a role in ensuring that the MHPAEA is correctly implemented, we encourage Connecticut, and all states, to wait for the final federal rule before taking further action. A final rule will hopefully address ambiguous areas in the IFR and provide us with uniform direction and guidance on the intent of the federal law. Each ABHW company operates in multiple states, and a consistent interpretation of the law will be the most beneficial for consumers, providers, purchasers, and payers. Currently, there are various interpretations (for example, Milliman's "Employer Guide for Compliance with the Mental Health Parity and Addiction Equity Act") about how the MHPAEA is supposed to be implemented; yet these interpretations are not binding, cannot be relied on for enforcement of the federal law, and furthermore do not always accurately reflect the intent of the federal regulators. Proper, consistent enforcement of the MHPAEA can only be achieved through the law, the regulations, and the sub-regulatory guidance from the federal agencies.

As you continue to discuss the implementation of the MHPAEA and await the final rule, we thought it might be helpful to provide you with ABHW's understanding of the following three important aspects of the IFR:

- Nonquantitative Treatment Limitations (NQTLS)
- Transparency Requirements
- Scope of Service

Nonquantitative Treatment Limitations (NQTLS):

The parity standard for nonquantitative treatment limitations (NQTLS) needs further explanation from the federal regulators; however, the interim final rule does make it clear that the standard is not the same as it is for financial requirements and quantitative treatment limits. The general parity standard for a financial requirement (e.g., copayment, deductible) or quantitative treatment limitation (e.g., day limits, visit limits) is that it cannot be more restrictive than the “predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits in the same classification.” However, for a NQTL the standard is “comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.” Further, these requirements “allow variations to the extent that recognized clinically appropriate standards of care may permit a difference.” The difference between the two is that the financial and quantitative treatment limitations parity comparison is based on a mathematical equation while the NQTL comparison is not based on a numerical formula and provides some leeway when clinically appropriate standards of care may permit a difference. The NQTL standard recognizes the intricacies in comparing a medical NQTL with a NQTL on the behavioral health side and purposefully does not require a rigid mathematical formula as the means of comparison. This is in recognition of the fact that parity of mental health and substance use disorder with medical/surgical benefits is of vital importance but at the same time recognizes that mental health and substance use disorder services do have some unique characteristics and differences from medical/surgical services.

Based on the MHPAEA, the IFR, the sub-regulatory guidance in the form of frequently asked questions (FAQs), the U.S. Department of Labor's 2012 Report to Congress: Compliance With the Mental Health Parity and Addiction Equity Act of 2008, and the February 2012 U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy “Short –Term Analysis to Support Mental Health and Substance Use Disorder Parity Implementation,” ABHW believes that if the following approach is taken and documented when comparing NQTLS for the medical/surgical benefits under the plan to the behavioral health benefits under the plan, the “comparable and no more stringently” parity test will have been met. Further federal guidance in this area would be helpful to validate for all stakeholders the appropriateness of the following framework for assessing NQTLS:

- The scope of medical management techniques used for medical/surgical benefits under the plan defines the possible medical management techniques that can be used for behavioral health benefits under the plan.
- The factors (e.g., cost growth, variability, high percentage of fraud, etc.) that are used to determine in what manner each medical management technique is applied also determine in what manner each technique may be applied in behavioral health. The scope of these factors and the processes (e.g., penalties for failure to obtain prior authorization, etc.) used to establish how the utilization management techniques are applied to medical/surgical management determines the scope of factors and the processes that can be used to establish when/how the application of utilization management techniques for behavioral health may occur.

- The criteria applied to these factors (e.g., 20% cost growth triggers retrospective review, 50% variability determines use of prior authorization requirement, 30% fraud rate triggers outlier management, etc.) establish when the application of the management techniques occurs on the medical side and also determine when the management technique can occur in behavioral health.

Establishing comparability and no more stringent application of NQTLs is complex and difficult. However, if parity in NQTLs remains part of the rule, a framework for analysis that is similar to what is outlined above is more appropriate than applying a strict mathematical formula to determine parity of NQTLs, and more consistent with the law, the regulations and the sub-regulatory guidance from the federal agencies.

Transparency Requirement:

The MHPAEA contains provisions regarding plan information which mandate the availability and disclosure of plan information. The requirements set forth in the MHPAEA, however, very specifically state what plan information must be made available and are not broad requirements for disclosure of all plan information. The requirements of the MHPAEA and the IFR for disclosure specifically address the availability and provision of information of two types: medical necessity criteria and communication of the reason for any denial of coverage or reimbursement under the plan.

The specific language related to availability of medical necessity criteria is found in Section 512(a)(4). It reads: “Availability of Plan Information. – The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary or contracting –provider upon request.” This language is limited to disclosure of the actual criteria themselves, not to any of the underlying policies, procedures, data, or materials used by the plan to develop the criteria, or any other plan information or documentation related to medical necessity criteria. This requirement’s limitation in terms of the type of information which plans are required to make available is appropriately reflected in the language of the IFR without substantive change from the language set forth in the statute.

With respect to the second disclosure required, the disclosure of the reason for any denial of coverage or benefits under the plan, the MHPAEA language is likewise precise and circumscribed at Section 512(a)(4): “The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health and substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.” This language, also reflected without substantive change in the IFR, does not require disclosure of information beyond the reason or rationale for the denial of benefits or payment. It does not, contrary to the opinions of some stakeholders, include a sweeping requirement for disclosure of policies, procedures, data, or information underlying the plan’s rationale for the denial.

States should enforce the two requirements stated above (already required by the state of Connecticut and the MHPAEA), but ABHW does not believe that states should add additional plan directed disclosures to the parity requirement. Doing so would create a further administrative burden on both medical and behavioral plans and possibly require disclosure of information that plans consider

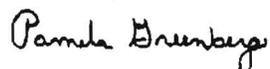
proprietary. Such requirements would also exceed the legal scope of the MHPAEA and the IFR as reflected in the plain language of the law and regulations. It is unclear that routine public disclosure of additional complex information makes identification of parity compliance or noncompliance any clearer; and, in terms of the state's assessment of parity compliance, the state already has access to any necessary additional information through the certificate of coverage that is filed with the state.

Scope of Service:

The MHPAEA was not intended to mandate coverage for mental health and addiction benefits or to mandate coverage for certain behavioral health services or treatments. The MHPAEA specifically provides that no such requirement is included but only that if such benefits are included, they must be included in parity with the medical/surgical benefits provided under the plan. If such a mandate was added, the impending cost is something that legislators would have to take into consideration. The IFR already mandates behavioral health coverage in six classifications if services are provided in those classifications on the medical side. Recognizing that this is a topic of much debate, we expect that the final rule will further clarify the scope of service issue and suggest that Connecticut wait to see what is articulated in the final rule on this topic.

Thank you for your consideration of the issues raised in this letter. I understand that there is a meeting on November 8th between the Department of Insurance and several health plan representatives, including several from ABHW member companies. In addition to the points raised above, we hope that at that meeting, if data collection to determine parity compliance is discussed, the group also discusses how the data is collected and compared using a standardized methodology to permit meaningful comparison and analysis for each plan. If you have any questions or would like to discuss any parity issues with us, please call me at (202) 449-7660.

Sincerely,



Pamela Greenberg, MPP
President and CEO