



Connecticut Nonquantitative Treatment Limitation “NQTL” Report

To

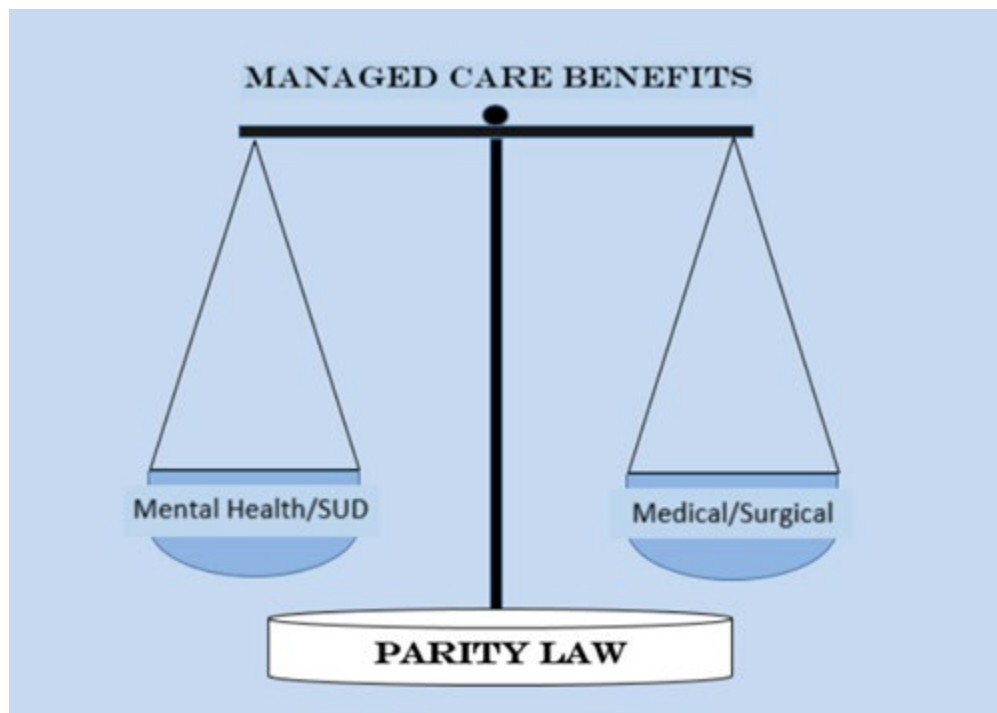
Insurance and Real Estate Committee

Presented by

Connecticut Insurance Department

Andrew N. Mais, Commissioner

April 14, 2021



Pursuant to CGS, Sec. 38a-477ee, the Connecticut Insurance Department is provided the 2021 report concerning nonquantitative treatment limitations submitted by pertinent insurers to the Commissioner (“Report”).

The Report includes each NQTL report that the Insurance Commissioner received pursuant to Subsection (b) of 38a-477ee for calendar year 2020.

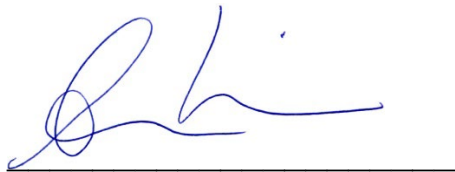
The Department compiled the report with data collected from 7 entities.

The data targets three (3) primary areas of disclosure:

- (1) Processes used to develop and select medical necessity criteria for mental health and substance use disorder benefits and medical and surgical benefits.
- (2) A description of all nonquantitative treatment limitations (NQTL’s) applied to mental health and substance use disorder benefits and medical and surgical benefits.
- (3) Documentation of every evidentiary standards supporting each medical necessity criteria used within each NQTL, full disclosure of all factors used within each NQTL and comparative analysis of the NQTL “as-written” and the NQTL “in-operation”, as designed and as applied to processes for mental health and substance use disorder, demonstrating that they are comparable and being no less stringently designed and applied to the similar medical and surgical benefits.

We hope you find this report informative.

Respectfully,



Andrew N. Mais
Insurance Commissioner

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Connecticut Nonquantitative Treatment Limitation Annual Report-2021

I. Introduction

Pursuant to C.G.S. Section 38a-477ee the Connecticut Insurance Department (“the Department”) hereby submits its 2021 NQTL annual report to the General Assembly. Included are the various reports received by the Commissioner pursuant to Subsection (b) of CGS, Section 38a-477ee reflecting calendar year 2020 data.

II. Background

In 2019, the Connecticut legislature passed Public Act 19-159 (the “Act”), which, among other things, mandating that each health carrier was required to submit, not later than March 1, 2021 and annually thereafter, a report to the Commissioner, in a form and manner prescribed by the Commissioner, containing the following information for the calendar year immediately preceding.

- (1) A description of the processes that such health carrier used to develop and select criteria to assess the medical necessity of (A) mental health and substance use disorder benefits, and (B) medical and surgical benefits;
- (2) A description of all nonquantitative treatment limitations that such health carrier applied to (A) mental health and substance use disorder benefits, and (B) medical and surgical benefits; and
- (3) The results of an analysis concerning the processes, strategies, evidentiary standards and other factors that such health carrier used in developing and applying the criteria and each nonquantitative treatment limitation, provided the commissioner is not permitted to disclose such results in a manner that is likely to compromise the financial, competitive or proprietary nature of such results. The results of such analysis shall, at a minimum:
 - (A) Disclose each factor that such health carrier considered, regardless of whether such health carrier rejected such factor, in designing each nonquantitative treatment limitation and determining whether to apply such nonquantitative treatment limitation;

- (B) Disclose any and all evidentiary standards, which standards may be qualitative or quantitative in nature, applied under a factor, and, if no evidentiary standard is applied under such a factor, a clear description of such factor;
- (C) Provide the comparative analyses, including the results of such analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the processes and strategies used to apply such nonquantitative treatment limitation, as written, to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, and the processes and strategies used to apply such nonquantitative treatment limitation, as written, to medical and surgical benefits;
- (D) Provide the comparative analyses, including the results of such analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, to medical and surgical benefits; and
- (E) Disclose information that, in the opinion of the Insurance Commissioner, is sufficient to demonstrate that such health carrier, consistent with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, as amended from time to time, and regulations adopted thereunder, applied each nonquantitative treatment limitation comparably, and not more stringently, to mental health and substance use disorder benefits, and medical and surgical benefits, and complied with 38a-488c and 38a-514c, 38a-488a and 38a-514, 38a-510 and 38a-544, and (IV) the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Subsection (c) of CGS, Sec. 38a-477ee precludes the Commissioner from divulging the name or identity of any health carrier or entity that has contracted with such health carrier, and mandates that such name or identity shall be given confidential treatment and not be made public by the Commissioner.

III. Description of Analysis

The federal MHPAEA defines nonquantitative treatment limitations as most commonly non-numeric standards that are designed and operationally applied in the management and delivery of healthcare. It is understood and recognized that these NQTL standards ultimately result in limiting the scope of Mental Health, Substance Use Disorder and Medical/Surgical benefits. The law establishes that NQTL's are an important tool in the management of healthcare, but it also specifically requires that these NQTL's be designed and applied comparably between Mental Health, Substance Use Disorder and Medical/Surgical benefits. The expectation is that NQTL's components, such as prior-authorization or concurrent care review practices, would be applied to Mental Health and Substance Abuse Disorder benefits comparably and no more stringently than they would be applied to Medical/Surgical benefits. Finally, the federal law points out that these benefits can maintain comparable in-practice limiting standards that produce incongruent final operational outcomes because of justifiable clinical differences or experiences, but that these instances require an advanced comparative analysis demonstration.

IV. Limitations of Analysis

The analysis is based on the 2020 health plan year and relies on information disclosed by the health carriers in their reports to the Department.

V. Key Findings

While the data is limited to what was requested and what was disclosed, there are some observations to be made. The data supporting any incongruent benefit outcomes were often omitted or insufficiently provided and analyzed. Also, there were certain instances where documentation was not sufficient to demonstrate a comparative analysis process that traced and demonstrated congruency throughout the entire NQTL life cycle, from as-written, to in-operation and to its final benefit outcome.

A more granular exploration of the comparative NQTL's and clinical criteria are shown between the benefits within the charts provided in Appendix 1.

VI. Detailed Findings

This discussion corresponds to the reports and charts attached as Appendix 1. The reader is encouraged to review those exhibits for full details.