

## **Mental Health Parity: Insurance Coverage and Utilization**

The Legislative Program Review and Investigations Committee voted to conduct a study in April 2005 entitled Mental Health Parity: Insurance Coverage and Utilization. The study focuses on the implementation of Public Act 99-284, which requires all group and individual health insurance policies in the state provide benefits for the diagnosis and treatment of mental conditions beginning January 1, 2000. The coverage cannot place a greater financial burden on an individual for access to diagnosis and treatment of mental conditions than it does for physical conditions under the same health policy. The scope of the study was to evaluate the impact of the mental health parity law and the utilization of mental health treatment in Connecticut on individuals enrolled in commercial health plans. The study examined the role of the Connecticut Insurance Department (CID) in implementing the mental health parity law because this agency is responsible for the regulation of health insurers and the products offered by them.

The committee's recommendations strengthen current state regulatory efforts through a variety of initiatives including improving the health policy amendment process when new mandates are adopted, requiring better mental health care information be submitted to CID, and incorporating it into the existing Consumer Report Card. In addition, the committee proposes transferring responsibility for compiling and publicizing the report card from CID to the Office of the Healthcare Advocate (OHA). The committee's recommendations also address the fragmented system that exists for handling consumer health care complaints.

### **Mental Health Care Provider Survey**

Mental health care providers were surveyed regarding their opinions on the impact of the mental health parity law, the utilization review process, access to mental health treatment, and reimbursement levels paid by insurers. The survey responses show that most mental health providers view the mental health parity law as having a positive impact on access to services. Other areas included on the survey asked providers their opinions on reimbursement levels, utilization review, claims processing, and whether they accept new clients. Responses in these categories were mixed.

### **Utilization and Cost Analysis**

Because of the lack of information collected by any state agency, the committee asked health insurers to provide aggregate utilization and cost statistics for general health and mental health in three categories – inpatient; partial hospitalization/intensive outpatient; and outpatient. For the three insurers providing the most complete responses, some general trends emerged:

- all measures of utilization of mental health treatment increased regardless of the level of care (inpatient or outpatient);

- a standard measure used to compare year-to-year costs, known as per member per year costs, also shows increases for both inpatient and outpatient mental health treatment; and
- the percentage of enrollees receiving any mental health services increased from about 6 percent in 1999 to almost 8 percent in 2004 for the two insurers that could provide these data.

*Given these increases, responses from the mental health provider survey, and the decrease in mental health utilization review request denials as shown in the briefing report, the committee found the mental health parity law has had a positive effect on access to mental health treatment. However, the weak quality of the data means that the impact of the parity law on utilization and cost can only be measured for those insurers that submitted complete data. Because the committee did find variation among the plans, specific patterns would need to be analyzed on a plan-by-plan basis to determine the reasons for those variations. Fully three insurers were unable to submit any quality cost or utilization data from even five years ago and therefore, the committee was unable to describe their experiences pre- and post-parity.*

## **Committee Findings and Recommendations**

*In general, the committee found:*

- *CID collects limited information on mental health utilization in the private insurance market and there are no requirements for insurers to file any mental health cost data.*
- *The mental health information that is submitted to CID, such as utilization review determinations for mental health treatment, is confusing because statistics about self-funded plan enrollees are sometimes included with those in fully insured health plans. Thus, tracking changes based on whether or not a group falls under the state's mental health parity mandate is not always possible.*
- *Furthermore, because mental health services are often "carved out" to a utilization review company, data are reported by these companies for all enrollees of health plans with whom they contract, making it difficult to track any statistics back to the actual health insurer.*
- *Finally, although there is another source of mental health data filed at CID -- the Health Plan Employer Data and Information Set (HEDIS), which is collected by the National Committee on Quality Assurance -- not all insurers report these data and regarding the data reported, they are not analyzed by the department to identify patterns or trends across insurers.*

***Health care policy review.*** The Life and Health Division reviews and approves all group and individual insurance policy forms, plans, applications, riders, and endorsements to ensure compliance with Connecticut insurance law. *The committee finds that the division does a thorough*

*review of policy language before approving new or amended policies. However, the committee also found no standard process is used by the division to inform health insurers of new state mandates or changes to existing mandates.* The division has, on occasion, sent out a bulletin to notify health insurers of new mandates and explain new mandate coverage requirements, but it is not standard practice. A consistent approach should be adopted by the division in informing health insurers of new or amended state mandates.

**1. The Connecticut Insurance Department should notify health insurers of any new or modified state mandate and ensure that health insurers amend any existing language prior to the date a state mandate becomes effective.**

*Utilization review determination statistics.* Connecticut law requires utilization review companies to annually file with CID the number of utilization review requests submitted by providers for preauthorization of an admission, service, procedure, or extension of inpatient stay. Companies must also report the number of preauthorization requests that are denied, appealed, and the appeal outcome. In 2001, the law was amended to require utilization review determinations related to mental or nervous conditions to be reported separately from all other determinations. The committee found several problems with the data:

- *only aggregate statistics are reported, including those based on enrollees of self-funded health plans, which are not regulated by CID;*
- *there is no category for partial utilization review denials (i.e., if the number of visits a provider requests were reduced by the utilization review company, that would be reported to CID as a denial); and*
- *the reasons for the request are not reported, thus no further analysis can be conducted and CID cannot identify if there is a particular type of service or treatment that is more frequently being denied.*

**2. C.G.S. Sec. 38a-226c(B)(12) shall be amended to require each utilization review company provide mental health statistics for enrollees of fully-insured health plans and those under self-funded ERISA plans separately and also provide by category:**

- **the reason for the request (i.e., inpatient admission, service, procedure, extension of inpatient stay, or outpatient treatment);**
- **the number of requests denied by type of request; and**
- **whether the request was denied or partially denied.**

*Managed care organization's report to the commissioner.* Connecticut law requires each managed care organization to annually submit a report to the CID commissioner on its quality assurance plans. The law requires health insurers provide statistical information that allows for comparisons across plans. Two of the measures that must be reported concern non-utilization review complaints received by the insurer and are:

- the ratio of the number of complaints received to the number of enrollees; and
- a summary of the complaints received related to providers and delivery of care or services and the action taken on the complaint.

*The committee found that the quality of information submitted varies from insurer to insurer and the committee could not make comparisons among plans because of different and incomplete information being filed.*

**Compilation and publication of the consumer report card.** Connecticut law requires the commissioner of CID annually compile and publish a consumer report card. The department surveys managed care organizations annually to obtain the information published in the report card. Its purpose is to provide health care users with comparative information about health plan performance

The committee believes the publication of the Consumer Report Card would be better located in OHA, including the underlying analysis. Given that this would be one of the primary responsibilities of the office and not an add-on function to insurance regulation, the committee believes the overall product would be improved.

**3. C.G.S. Sec. 38a-478l shall be amended to transfer the responsibility for development and publication of a consumer report card on all managed care organizations to the Office of Healthcare Advocate.**

*Contents of the report card.* The committee found the report card is focused on services related to physical conditions and the card does not contain any specific information on: participation and availability of mental health providers; mental health quality measures; or total mental health utilization review statistics including requests, denials, or enrollee appeals. The committee found that while this information is already submitted to CID, it is not analyzed or compiled in the report card.

**4. The Consumer Report Card required under C.G.S. Sec. 38a-478l shall include the following behavioral health measures:**

- **the number of utilization review requests for mental health conditions for enrollees of fully-insured health plans and those under self-funded ERISA plans separately and by:**
  - **the reason for the request (i.e., inpatient admission, service, procedure, extension of inpatient stay, or outpatient treatment);**
  - **the number of requests denied by type of request; and**
  - **whether the request was denied or partially denied;**
- **discharge rates from inpatient mental health and substance abuse care;**

- average lengths of stay and number of treatment sessions for enrollees receiving inpatient and outpatient mental health and substance abuse care and treatment;
- percentage of enrollees receiving mental health services overall, and categorized by inpatient and outpatient mental health and substance abuse care and treatment;
- percentage of enrollees who receive 7 day and 30 day follow-up care after hospitalization for mental illness;
- percentage of enrollees receiving anti-depressant medication management;
- claims expenses on a per member per month basis by:
  - inpatient mental health;
  - inpatient substance abuse;
  - outpatient mental health;
  - outpatient substance abuse; and
  - overall;
- the ratio of mental health providers in an insurer's network to the total number of enrollees having access to the network;
- the method by which behavioral health benefits are managed (i.e., either directly or through a "carve-out" to a utilization review company); and
- if behavioral health benefits are "carved-out", whether the utilization review company has received accreditation from NCQA or peer review organization.

*Ongoing examination of mental health measures.* The committee anticipates certain issues may arise related to the measures used in the report card and their validity. Public Act 05-280 established a Mental Health Parity Workgroup based on a recommendation in the Lieutenant Governor's Mental Health Cabinet Report (discussed in the briefing report). The Office of Healthcare Advocate was charged with leading the group. The workgroup has met several times since June 2005 and has begun to discuss a variety of issues concerned with mental health care and health insurance coverage. The committee believes the workgroup would be an appropriate forum for further discussions regarding the mental health measures that should be included in the Consumer Report Card.

- 5. The Mental Health Parity Workgroup established by Public Act 05-289 should periodically identify the mental health utilization measures that should be included in the Consumer Report Card by October 1, 2007, and annually thereafter. If no new measures are identified, those in effect the previous year should be used.**

**Consumer health care complaints** Three state agencies respond to health care complaints, including CID, the Office of the Healthcare Advocate, and the Office of the Attorney General. The bulk of complaints is filed with the CID Consumer Affairs Division. However, the committee found

that the majority concern unfair claims practices and about 40 percent of those complaints are filed by providers. In contrast, most of the complaints filed with the healthcare advocate and the attorney general are from health plan enrollees.

In addition, the Consumer Affairs Division publishes an Annual Accident & Health Ranking which lists health insurers with no justified or questionable complaints and numerically ranks those with justified and/or questionable complaints. A similar ranking methodology is used for companies licensed as health maintenance organizations (HMOs). *The committee finds these rankings are seriously flawed, given that neither the complaints received by the Office of the Healthcare Advocate or the Office of the Attorney General are included in either of the ranking calculations.*

- 6. The Office of the Attorney General and the Office of the Healthcare Advocate should forward a quarterly report to the Connecticut Insurance Department containing information on each complaint that at a minimum includes: the source of the complaint, the reason for it, the company named in the complaint, and its resolution. The Consumer Affairs Division should include these complaints in its database when generating information for the Market Conduct Division for use in its examinations, and when calculating its annual rankings.**

*Regulation of the managed care industry by CID.* Although the committee's study focused only on a small segment of the private insurance market and then only highlighting mental health parity coverage, some of the committee's recommendations impact department activities beyond mental health parity. Additionally, some of the findings identify issues regarding how well CID regulates the health insurance industry given the broad and sweeping changes in the market over the past decade.

- 7. The Legislative Program Review and Investigations Committee should consider a study of the Connecticut Insurance Department's operations, activities, and processes related to the regulation of health insurance including managed care as it sets its agenda for 2006.**