

Findings and
Recommendations

Mental Health Parity:
Insurance Coverage
and Utilization

December 13, 2005

Legislative Program Review
& Investigations Committee

Introduction

Background

The Legislative Program Review and Investigations Committee voted to conduct a study in April 2005 of Mental Health Parity: Insurance Coverage and Utilization. The study focuses on the implementation of Public Act 99-284 that 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 requirement affects plans offered by HMOs and health insurers that cover: 1) basic hospital expenses; 2) basic medical-surgical expenses; 3) major medical expenses; and 4) hospital or medical services.

The scope of the study is to evaluate the compliance with the mental health parity law on the utilization of mental health treatment in Connecticut for individuals enrolled in commercial health plans. Thus, the study did not examine whether the types of services available under the law need to be expanded. The study examines 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. It also reviewed the activities of the Office of the Healthcare Advocate (OHA), formerly the Office of the Managed Care Ombudsman, to determine its role in educating consumers on health plan choices and handling consumer health care complaints. The Office of the Attorney General and how it responds to complaints, specifically regarding mental health coverage, was also reviewed.

The Connecticut mental health parity law is one of the most comprehensive in the country because it defines mental health conditions broadly, includes substance abuse, and covers all commercially insured populations. However, since it is a state insurance mandate, only one-third of Connecticut's population is covered by the law because it does not apply to the three major public health insurance programs -- 1) Medicaid; 2) the medical portion of State Administered General Assistance administered by the Department of Social Services; or 3) Medicare -- or to self-funded health care plans covered under the federal Employee Retirement Income Security Act (ERISA).¹ Unless specifically noted, this report focuses only on fully insured commercial health policies.

Although it has been almost six years since insurers were required to provide mental health benefits on par with medical benefits, the committee found it difficult to evaluate the

¹ The state insurance department does not have jurisdiction over most self-insured health plans, which fall under the Employee Retirement Income Security Act (ERISA). ERISA is a federal law that is enforced by the U.S. Department of Labor, Employee Benefits Security Administration (DOL-EBSA). If a member of a self-insured health plan needs assistance, he or she would contact the DOL-EBSA. Self-funded government plans and church plans do not fall under ERISA but are not required to provide state mandates because they are self-funded. According to information submitted to CID as of December 2003, about 1.1 million individuals are enrolled in self-funded plans. There are slightly less than 1 million individuals enrolled in public programs (i.e., Medicare, Medicaid, and SAGA).

law's impact because almost no information is available at a state agency level that measures utilization, accessibility and cost of mental health services in the private insurance market. Because of this, the committee worked with representatives of the health insurance industry to obtain mental health care utilization trend data and the costs incurred by insurers for these services. Although under no statutory obligation to provide the data, the six largest health insurers in the state complied with the committee's request. However, the reliability of the data varied from company to company and the committee found only three companies submitted data that could be trended back to before the parity law was enacted.

Based on 1997 to 2004 data submitted by the three insurers, the committee found that utilization of mental health services increased in every standardized measure examined. Furthermore, insurers' costs for mental health treatment, calculated on a "per member per year" basis also increased over the time period reviewed. Although factors other than the parity law likely contributed to utilization increases -- such as broader public awareness campaigns urging individuals to seek treatment for mental illness and the simultaneous explosion in direct advertising of prescription drugs to consumers -- many insured individuals most likely sought treatment because of the expanded coverage requirements under the parity law and the requirement that co-pays be on par with those for medical treatment. The committee believes that more complete data by all health insurers would need to be submitted to measure the full impact of the law.

The committee also conducted a survey of certain mental health providers who are eligible for insurance reimbursement under the law. Providers were surveyed regarding their opinions on the impact of the law, the utilization review process, access to mental health treatment, and reimbursement levels paid by insurers. Although survey results were somewhat mixed, 71 percent of the survey respondents indicated that the law has had a positive impact on expanding access to mental health services. According to the providers surveyed, variations in health insurers and utilization review companies, as well as in plan benefit structures, often had the greatest impact on the ability to access services.

The committee's recommendations call for strengthening regulatory oversight through a number of initiatives and by integrating mental health measures into already existing consumer publications that provide information about selecting and comparing health plans. This would allow consumers to better assess health insurer performance in providing mental health treatment and compare certain quality measures across plans. Regulators could also use this information to monitor mental health utilization and ensure that consistent and fair decisions are being made across insurers. In addition, the recommendations transfer the responsibility for compiling and publishing the consumer guide from CID to the Office of Healthcare Advocate. The final recommendation restructures how CID aggregates health care complaint information since no single agency responds to them.

Study methodology. In conducting the study, the program review committee staff reviewed federal and state laws related to mental health parity, as well as specific studies conducted in other states concerning the cost of implementing parity laws. Committee staff interviewed state agency personnel in CID concerning how the parity law has been implemented and how the department tracks mental health utilization and cost changes in the private insurance

market. Interviews were also held with officials of the Department of Mental Health and Addiction Services (DMHAS); the Office of the Healthcare Advocate (OHA, formerly the Office of the Managed Care Ombudsman); the Office of Health Care Access (OHCA); and the Office of the Attorney General (AG) to determine the role of these agencies, if any, in monitoring parity requirements in the private health insurance market. Representatives from the managed care industry, mental health care providers, and advocates for the mentally ill were also interviewed.

The review also included analysis of health insurers' mental health utilization and cost data, administration of a mental health care provider survey, and an analysis of the system in place to respond to consumer health insurance complaints, which are received and acted on by three different state agencies.

Report organization. Section I summarizes the results of the mental health provider survey. Section II describes the experience of three of the six largest health insurers licensed in the state regarding enrollee mental health utilization and cost trends since the first parity law in Connecticut was enacted.² Section III contains the committee's findings and recommendations related to the role of the insurance department and other state agencies in monitoring and tracking mental health services for individuals and groups enrolled in private insurance health plans, and in responding to consumer complaints about mental health coverage. Appendix A shows the complete results of the mental health care provider survey. Appendix B contains the mental health utilization and cost data request that was submitted to representatives of health care insurers.

² A limited mental health parity law was enacted in 1997 requiring parity only for certain biologically based mental illnesses. A more comprehensive law was adopted in 1999.

Mental Health Care Provider Survey Results

The program review committee conducted a survey of mental health care providers who are eligible for insurance reimbursement under the parity law. This includes licensed psychiatrists, clinical psychologists and social workers, advanced practice registered nurses, professional counselors, and licensed and certified alcohol and drug counselors.

The survey contained 36 questions and elicited responses from providers on the parity law's impact in expanding access to mental health treatment, experiences with the utilization review process, state agency handling of health care complaints, and health insurance reimbursement levels. The survey was administered electronically after committee staff obtained e-mail addresses from representatives of the following associations:

- Connecticut Psychiatric Society;
- Connecticut Psychological Association, Inc;
- Connecticut Society of Nurse Psychotherapists;
- National Association of Social Workers, Connecticut Chapter;
- Connecticut Counseling Association; and
- Connecticut Association of Marriage and Family Therapists.

In this section, selected results of the survey are highlighted. Where noted, psychiatrist responses are separately reported if the response differed significantly from the overall results. For the complete survey results and copy of the survey instrument see Appendix A.

Survey caveats. There are several caveats associated with the survey results. First, the survey was not randomly administered and is not statistically valid. Thus, the overall accuracy of generalizations from the survey about the opinions of mental health providers cannot be determined. The survey was used solely to quantify selected mental health provider opinions and was targeted only to mental health care providers who are eligible for insurance reimbursement under the parity law. Since the Department of Public Health (DPH) does not maintain e-mail addresses for its licensed providers, committee staff worked with the provider associations to obtain them instead. However, not all mental health providers are members of associations and not all association members have e-mail addresses, so none of these providers would have received a survey. Inquiries from providers that fall under the parity law but are not association members were e-mailed the survey separately.

In addition, some of the associations, such as the Connecticut Chapter of the National Social Workers Association could only provide e-mail addresses for all of its members, not just those licensed as clinical social workers. To address this issue, the first survey question asks the type of provider responding and if the respondent was not eligible for reimbursement they should have been excluded from answering the rest of the survey questions. However, this does not prevent them re-entering the survey under an accepted occupation should they have desired to

complete the survey. Finally, no e-mail addresses could be obtained for licensed or certified alcohol and drug counselors.

Survey Results

The committee received a total of 632 responses to the survey, although only about 350 providers actually responded to any of the survey questions, and that number varies from question to question. Table I-1 shows the total number of survey respondents by type of mental health provider. Clinical social workers were the largest provider group replying to the survey, followed by clinical psychologists and psychiatrists.

<i>Type of Provider</i>	<i>No. Responding</i>	<i>% of Total</i>
Psychiatrists	81	13%
Clinical Psychologists	81	13%
Nurse Psychotherapists	31	5%
Clinical Social Workers	263	42%
Professional Counselors	62	10%
Marital and Family Therapists	64	10%
Licensed or Certified Alcohol and Drug Counselors ¹	2	--
None of the Above	48	8%
Total	632	100%

¹Committee staff did not have e-mail addresses for licensed or certified alcohol and drug counselors.
Source: LRP&IC survey of mental health care providers.

Impact of the parity law. Mental health care providers were surveyed about the effectiveness of the mental health parity law in four areas: 1) expanding access to mental health treatment; 2) expanding access to mental health providers; 3) improving the quality of mental health; and 4) reducing the stigma associated with mental illness. The responses indicate:

- only 58 percent of psychiatrists compared to 71 percent of all survey respondents thought the mental health parity law was either “very effective” or “somewhat effective” in expanding access to treatment;
- only 47 percent of psychiatrists believed the law had expanded access to mental health providers compared to 59 percent of all respondents;
- slightly more than half (55 percent) of all survey respondents thought the parity law reduced the stigma associated with mental illness, while less than half of psychiatrists thought it had; and
- about half of all respondents believed the law was “not effective” in improving the quality of mental health treatment, and more than half of psychiatrists believed this.

Mental health providers were also asked to categorize their experiences with a variety of health insurance related issues in terms of whether the parity law had an impact on: the

utilization review process; level of reimbursement provided; processing of providers' claims; and expanding provider networks. The percent of responses attributable to each category are shown in Table I-2.

<i>Health Insurance Issue</i>	<i>Improved</i>	<i>No Effect</i>	<i>Worsened</i>	<i>Don't Know</i>	<i>Total</i>
UR process	18%	31%	15%	36%	100%
Provider reimbursement rates	9%	41%	25%	26%	100%
Processing claims	11%	42%	16%	31%	100%
Expanding provider networks	17%	33%	15%	35%	100%

Source: LPR&IC survey of mental health care providers.

The table shows the most common response of mental health providers was that the parity law had either “no effect” on the utilization review process or did not know the effect of the law. In terms of provider reimbursement rates, many of the respondents believed the parity law had “no effect”, while less than 10 percent thought the law “improved” reimbursement rates.

Characteristics of survey respondents’ practices. The program review committee asked providers to describe several characteristics related to their practice. The responses indicate the largest number:

- had been in practice 20 years or more;
- saw between 20 and 30 patients per week;
- were in private practice in the community (70 percent);
- were in solo practice (77 percent);
- did not employ administrative staff to handle billing and claims (59 percent) or utilization review requests (84 percent);
- did not specialize in a particular area of mental health treatment;
- treated adults, but only about three-quarters treated adolescents, and less than half (46 percent) treated children (although only 20 percent of psychiatrists indicated that they treated children).

Private insurance. Providers were also questioned regarding their experiences with managed care insurance. Although 70 percent of the 345 mental health care providers responding to the survey questions stated that they accept managed care insurance, only 55 percent were accepting new patients with insurance and another 22 percent stated that it depends on the insurer. Furthermore, about 45 percent of all respondents had declined to take a new patient because the patient was covered by a particular company or health plan. The biggest reason given for not accepting new patients was because of inadequate reimbursement, followed by claim reimbursement delays and poor customer service.

Waiting times for an appointment. New patients typically do not have to wait more than one week to obtain an appointment, according to the mental health providers surveyed. Twenty-three percent of providers stated that a new patient typically has to wait less than three

days to receive an appointment and another 38 percent of providers stated that the typical wait time was between three days and one week. Only 6 percent stated that new patients typically had to wait more than three weeks to get an appointment.

When wait times for appointments with psychiatrists were examined, the length of time to receive an appointment increased. While 40 percent of psychiatrists stated that patients had to wait less than a week for an appointment, almost a third responded that wait times were more than 15 days.

Prior authorization and the utilization review process. Providers were also surveyed regarding their experiences with obtaining prior authorization for inpatient and outpatient mental health services. Based on a response from 326 providers, 51 percent stated their experience with the utilization review process was “generally positive”, while 36 percent stated it was generally negative.

Providers were also asked to specifically rate their experience in obtaining prior authorization for each type of mental health treatment. Almost half of the mental health providers responding to the survey didn’t have much experience related to the utilization review process, requests for inpatient admissions, continued lengths of stay, or partial hospitalization treatments. Psychiatrists as a group had such experience so the committee examined their prior authorization responses separately. The psychiatrists obtaining prior authorization for:

- initial outpatient visits was “not difficult” according to 60 percent of respondents;
- inpatient admissions, intensive outpatient treatment, and additional outpatient visits was rated as “somewhat difficult” by about half of the respondents; and
- inpatient continued stay and partial hospitalization treatment was categorized as “very difficult” by 46 percent and 37 percent of respondents respectively.

The responses of mental health providers for obtaining prior authorization for outpatient treatment were similar to those given specifically by psychiatrists. Sixty-three percent of all providers stated that obtaining prior authorization for initial outpatient visits was “not difficult”.

Providers were also asked how frequently they have altered the mental health treatment given to a patient because of the utilization review process. Table I-1 shows the majority of respondents indicated that they had occasionally altered treatment. Of those that had altered treatment, 85 percent said that they reduced the frequency of visits.

Experience with state agency handling of complaints. Although a limited number of providers who responded to the survey have filed a complaint with any of the three state agencies that handle health care complaints -- CID, the Office of the Healthcare Advocate, or the Office of the Attorney General -- if a complaint was filed, the most common reason given was because of claim denials and delays followed by prior authorization denials.

<i>How Treatment Was Altered</i>	<i>Number of Responses</i>	<i>Percent</i>
Inpatient Treatment Instead of Outpatient	8	3%
Outpatient Treatment Instead of Inpatient	61	24%
Reduced Frequency of Visits	213	85%
Treated in Group Rather than Individual Therapy	31	12%
Prescribed Drugs Instead of Treatment	29	12%
Changed Medication	36	14%
Other	45	18%
Total	423*	

*Responses do not equal the number of respondents because providers could select multiple categories.
Source: LPR&IC survey of mental health care providers.

In terms of the overall performance of the department or office in resolving the filed complaint, the Office of the Attorney General was rated “very effective” by 31 percent of the respondents and “somewhat effective” by another 15 percent. The Office of Healthcare Advocate also had a majority of respondents (52 percent) stating that it was “very effective” or “somewhat effective” in resolving complaints. The insurance department received the lowest rating by providers with only 37 percent indicating it was “very effective” or “somewhat effective.”

Summary

The survey responses show that most mental health providers view the mental health parity law as having a positive impact on access to services. Many of the areas included on the survey also 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

The purpose of this study is to examine both the coverage and utilization aspects of the 1999 mental health parity law since it became effective January 1, 2000. While the Connecticut General Assembly adopted a comprehensive mental health parity law, the law did not require health insurers to report utilization or claim data to CID, the regulatory agency responsible for ensuring the new mandate was implemented. Thus, the committee found almost no mental health utilization and cost information exists at the state level since ensuring that mental health coverage is provided by health insurance policies in accordance with the parity law is only a minor part of CID's broader managed care regulatory responsibilities.

Health Insurance Data Request and Response

Because of the lack of information being collected by any state regulatory agency, committee staff met with representatives of the major health insurers in the state and submitted a detailed request for 1997-to-2004 mental health utilization data for fully insured enrollees. Health insurers were asked to provide aggregate utilization and cost statistics for general health and mental health in three categories – inpatient; partial hospitalization/intensive outpatient; and outpatient. The purpose of the committee staff's request was to examine some broad measures that would allow for a basic assessment of the impact of the mental health parity law. The formal data request by committee staff to the insurers' representatives is contained in Appendix B.

Data were obtained from the six largest licensed health insurers in the state: Anthem Blue Cross, Aetna, CIGNA, ConnectiCare, Health Net, and Oxford. Altogether, these health insurers provide fully insured health care coverage for about 920,000. None of the insurers were able to fully comply with the committee staff's request because:

- some of the statistics requested by committee staff are not tracked by insurers; and/or
- many insurers contract with behavioral health organizations for the management of mental health services and insurers change these organizations frequently. Insurers were unable to obtain archived data from former behavioral health organization.

Because of the proprietary nature of the information, the identities of the health insurers providing data to the program review committee staff were masked and referred to as Plan A, Plan B, etc. Three of the six insurers submitted fairly complete data and the analysis below focuses on their responses. The data from two of the insurers were not used by committee staff because of staff concerns regarding its reliability. Only select measures provided by one of the other health care insurers are presented since only one or two years of data were provided.

Data Analysis

The limited data provided by health insurers does show there are considerable increases in both utilization and spending trends since 1997. *Given these increases, responses from the mental health provider survey, and the decrease in mental health utilization review request denials as shown in the staff briefing, the committee finds 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. 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.*

For the three insurers providing the most complete responses, some general trends emerged:

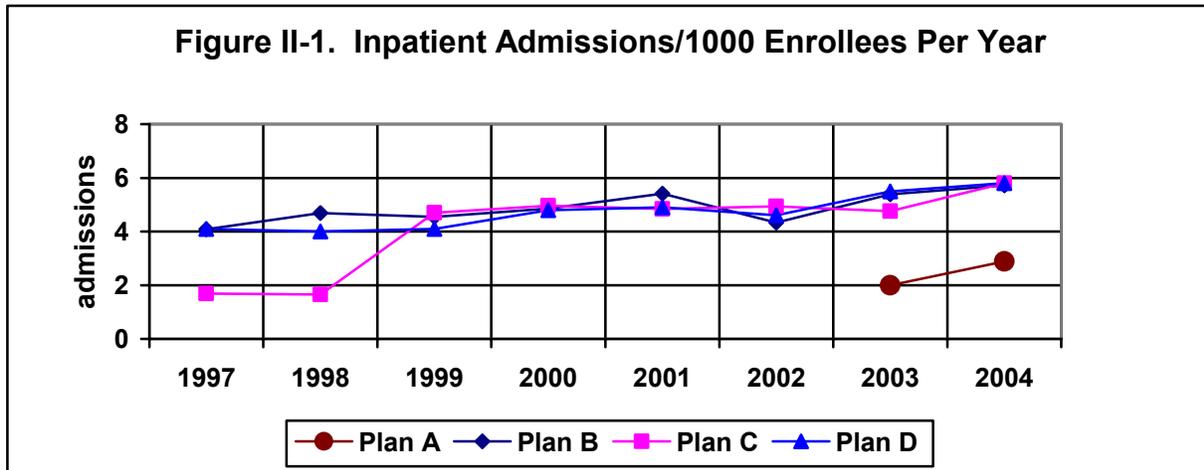
- all measures of utilization of mental health treatment increased regardless of the level of care (inpatient or outpatient);
- a standard measure used to compare year-to-year costs, known as per member per year costs, also shows increases for both inpatient and outpatient mental health treatment; and
- 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.

While the committee recommends later in the report that all health insurers submit better data to CID so that comparisons on various mental health measures can be performed, the analysis contained in this section highlights the data submitted from 1997 by three large health insurers who cover a significant portion of the fully insured population. Two years of data, 2003 and 2004, provided by a fourth insurer, are also included. There are several key points in time that need to be remembered when comparing the data from year to year:

- 1997 is used as the base year for most of the measures since this year was prior to any parity law, including the biologically based mental health parity law, being adopted;
- 1999 is used because it was after the biologically based parity law was adopted but before the 1999 full parity law was required to be implemented;
- 2001 is used because the 1999 parity law had been in place for over one year; and
- 2004 is used because it is the year for which the most current data are available.

Inpatient Mental Health Statistics

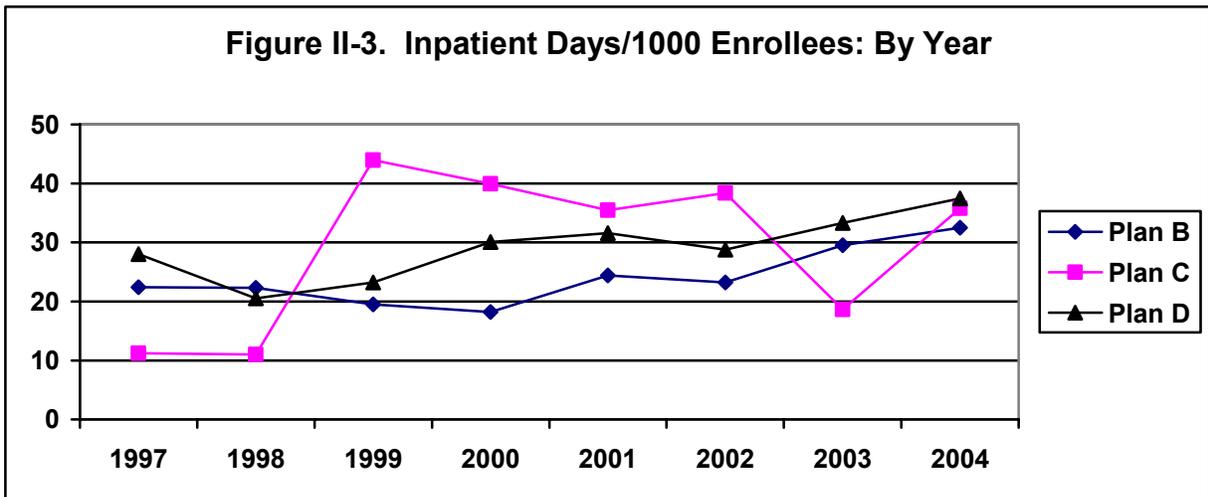
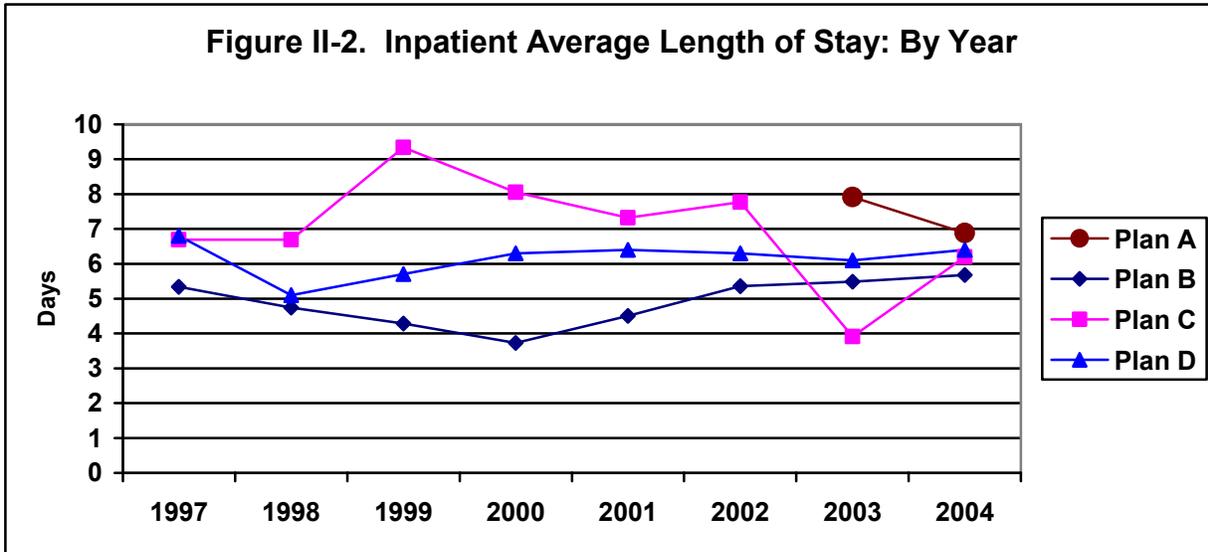
Inpatient admissions. Figure II-1 shows the number of inpatient mental health admissions per 1000 enrollees, a standard measure of utilization. As shown in the figure, the number of inpatient admissions per 1000 enrollees has increased for all three plans with data since 1997, with the greatest overall increase occurring for Plan C. According to the insurer providing the Plan C data, the reason for the spike from 1998 to 1999 was because it was the first year that biologically based mental health coverage was required. Data for Plan A were only provided for the two years shown.



By 2004, three of the four health plans shown were almost identical in the number of inpatient admissions per 1000 - which may indicate that similar medical protocols are used to determine medical necessity and appropriateness for inpatient level of care. Although 60 days of inpatient mental health care annually was mandated for group policies prior to either of the parity laws being adopted, the increase in admissions may be a result of expanding mandated coverage to individual policies because those policies had no mental health coverage requirement.

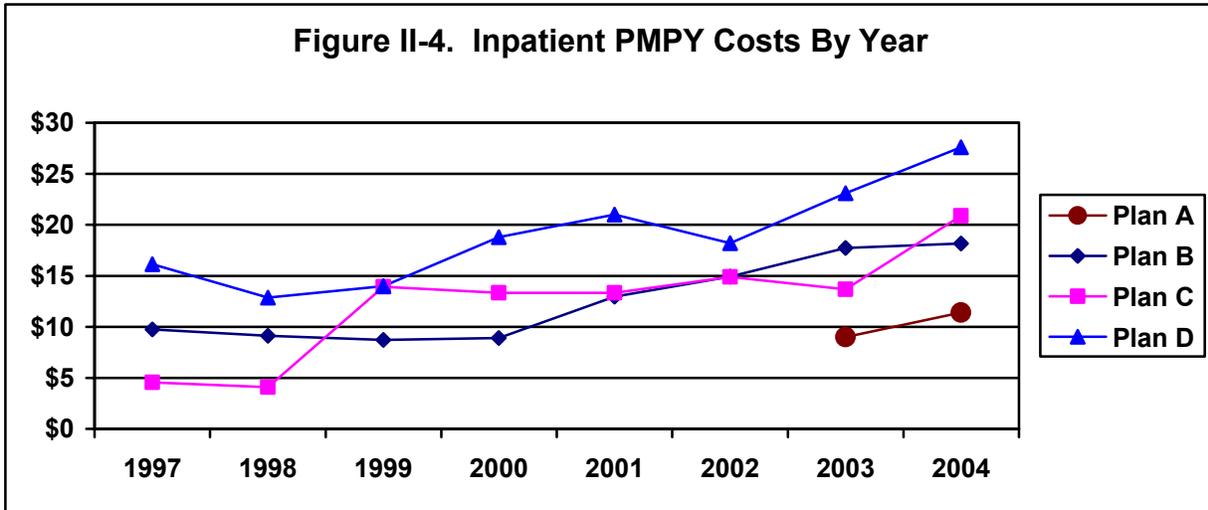
Average length of stay. A standard hospital measure used to determine the average amount of time between admission and discharge for patients is average length of stay (ALOS). Figure II-2 shows the average length of stay for enrollees hospitalized for behavioral mental health reasons. Plan C had the most volatility in ALOS. By 2004, the ALOS was similar for all four insurers – about 6 days. Although more enrollees are being admitted for inpatient hospital services (shown in Figure II-1), the ALOS only increased for Plan B when compared to ALOS in 1997. Thus, it doesn't appear the parity law has influenced the amount of time individuals are hospitalized.

Inpatient days. Another standard unit of measurement of utilization refers to the number of hospital days that are used in a year per thousand enrollees. Figure II-3 shows mental health inpatient days per 1000 members for the full eight-year period. Plan C had the most volatility from year-to-year, but by 2004, all plans were at similar levels.



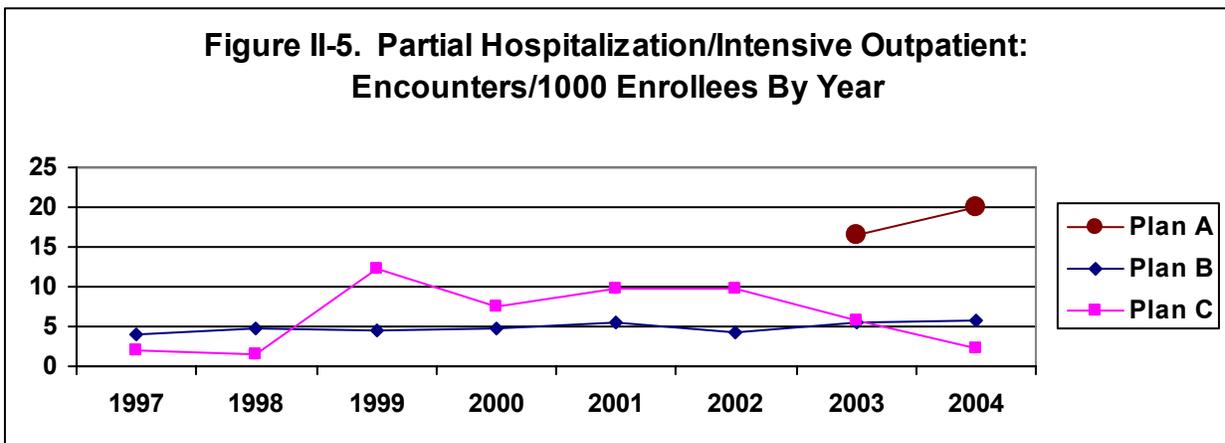
Costs. Figure II-4 shows per member per year (PMPY) costs for inpatient mental health treatment for three insurers with complete cost data (two years of data from a fourth insurer is also shown). Trends for all three plans with data from 1997 show overall costs increased when two points in time are compared -- 1997 and 2004 -- with Plan C experiencing the greatest overall increase (348 percent) in PMPY costs. Furthermore, all insurers examined had higher PMPY costs in 2004 than in any other year shown. Even after adjusted for inflation using 1997 as the base year³, the percentage increase in costs between 1997 and 2004 were 59 percent for Plan B, 289 percent for Plan C, and 45 percent for Plan D. Plan A had a 23 percent increase, adjusted for inflation, between 2003 and 2004.

³ <http://www.bls.gov/cpi/home.htm>, CPI inflation calculator.



Partial Hospitalization/Intensive Outpatient Data

Not all plans provided information on a middle category of mental health treatment -- partial hospitalization/intensive outpatient -- which provides less intensive treatment than inpatient but more intensive than outpatient. Figure II-5 shows the three plans that were able to separate out these data. The figure shows that: Plan C actually decreased the number of encounters per 1000 enrollees over time; Plan B's experience was relatively flat; and Plan A increased the number of encounters per 1000 enrollees. One plausible reason why Plan A may have so many more encounters per 1000 enrollees than the other two plans is because this plan may use partial hospitalization as a treatment option instead of admitting enrollees to inpatient hospitalization settings (see Figure II-1).

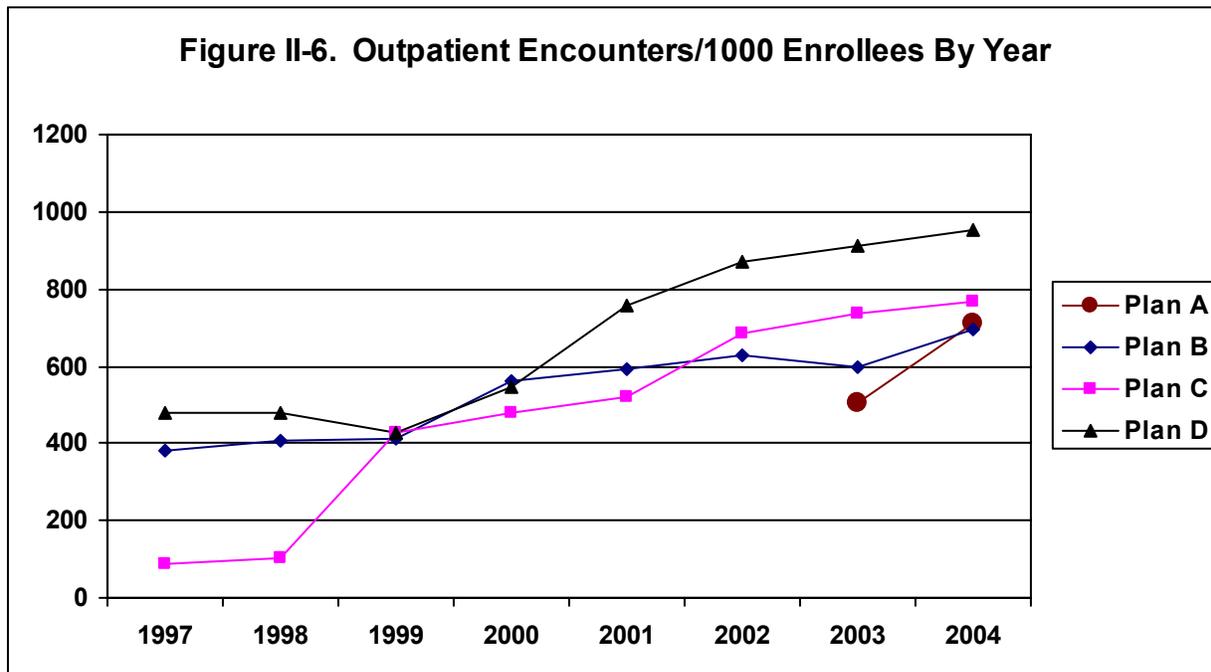


Outpatient Mental Health Data

Outpatient encounters. The program review committee also examined data related to outpatient mental health utilization since 1997. One standard measure used to measure utilization -- outpatient encounters per 1000 enrollees -- is shown in Figure II-6. An encounter is

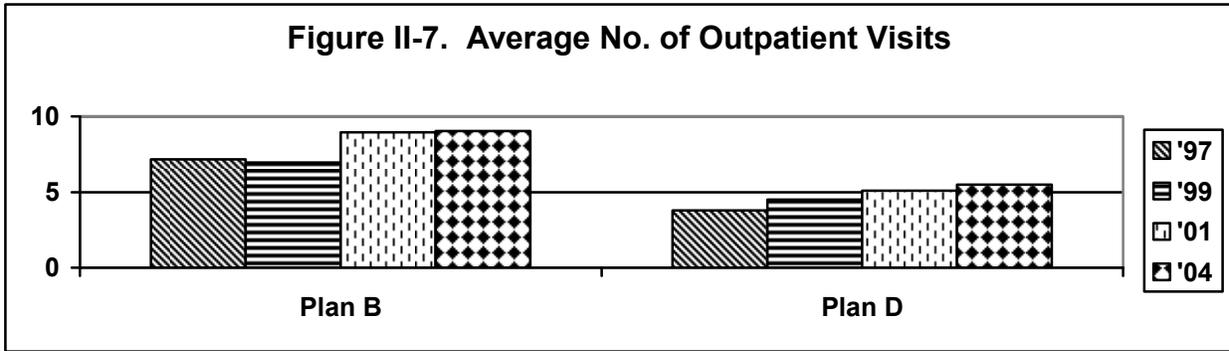
defined as a face-to-face meeting between an insured person and a health care provider where services are provided or rendered.

As the figure shows, there has been tremendous growth in the number of outpatient encounters per 1000 enrollees. In 1999, almost all plans had the same number of outpatient encounters per 1000 (slightly more than 400 per 1000 enrollees). These rates have increased significantly since then with Plan B experiencing 81 percent growth from 1997 to 2004 and Plan C increasing 763 percent over the same time period. A likely reason that Plans A, B, and C lag behind Plan D in this measure is because these plans reported partial hospitalization/intensive outpatient data and outpatient encounters separately. Plan D however could not provide this data and it is aggregated into the outpatient encounter data shown in Figure II-6.

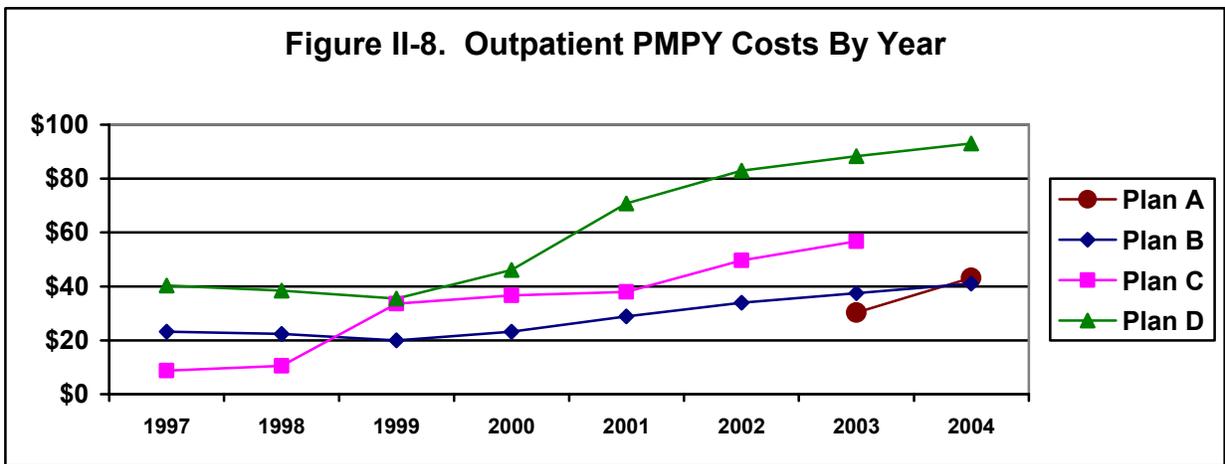


While the figure shows that there are more encounters per 1000 enrollees, it cannot show whether more enrollees are accessing mental health services or more services are being provided to the same number of enrollees. Further data would need to be obtained in order to perform analysis to determine the reason for the growth.

Average number of outpatient visits. Only two insurers were able to identify the average number of outpatient visits over time (shown in Figure II-7). Both plans show that the average number of visits in 2004 was greater than in any other year examined. For Plan B, the average number did not change much between 1997 and 1999, but grew after the 1999 parity law was adopted. Plan D shows steady growth since adoption of the 1997 biologically based parity law.



Mental health costs. The last measure examined by the committee -- mental health outpatient PMPY costs -- is shown in Figure II-8. This measure shows there has been tremendous growth in insurer costs since the 1999 parity law was adopted, with the exception of Plan C which actually increased PMPY costs between 1997 and 1999. Overall, costs have increased between 1997 and 2004, after adjusting for inflation, by 50 percent for Plan B, 137 percent for Plan C, (data were only provided for this measure up to 2003), and 96 percent for Plan D. Plan A's inflation-adjusted PMPY costs increased 39 percent between 2003 and 2004.



Summary

Although the six health insurers were very cooperative in providing data to the committee, the quality of the data varied and committee staff had to exclude two plans from the analysis because of data that appeared to be unreliable. In addition, reasons for variations in utilization and costs among health plans could not be explained because more comprehensive and detailed data would need to be submitted by insurers to provide those explanations.

Findings and Recommendations

Responsibility for ensuring that fully insured health insurance policies provide state mandated health benefits rests with the Connecticut Insurance Department, the agency charged with regulating the insurance industry in Connecticut. However, as was discussed in the briefing report, because mental health parity is a legal requirement, not a specific program, the department's activities are not specifically focused on mental health coverage. Rather, the role of CID is to ensure compliance by the health insurance industry with Connecticut laws and regulations, as well as the terms and conditions stated in health care contracts.

As noted throughout this report, there are significant limitations to the data and information available to comprehensively assess the mental health parity law. For example, 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 committee also found the mental health information, such as utilization review determinations for mental health treatment that is submitted to CID, 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 impossible 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.*⁴

The committee's recommendations in this section 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 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. The recommendations also address the fragmented system that exists for handling consumer health care complaints.

⁴ The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization dedicated to quality oversight and improvement initiatives at all levels of the health care system, from evaluating entire systems of care to recognizing individual providers who demonstrate excellence. The Health Plan Employer Data and Information Set, or HEDIS, is a tool used to measure performance on important dimensions of care and service. HEDIS is designed to provide purchasers and consumers with the information they need to reliably compare the performance of managed health care plans. Altogether, there are more than 60 different measures in HEDIS, but only a few are specific to mental health. NCQA's funding comes from a wide variety of sources including government contracts, grants from private foundations and corporations, educational conference fees, publications sales and accreditation and certification survey fees.

Connecticut Insurance Department

The activities of three of the nine divisions – Life and Health, Market Conduct, and Consumer Affairs – involved in ensuring compliance with the mental health parity law were described in the briefing report. Findings and recommendations related to the functions performed by these divisions are presented below.

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. In terms of ensuring mental health benefits are covered, the division confirms that language contained in a policy mirrors statutory requirements and no exclusions are noted in the policy that are contrary to law.

The committee finds that the division does a thorough review of policy language before approving new or amended policies. The review includes an examination to ensure appropriate language exists for all state mandates, including mental health parity. *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.* For already-approved health policies, it is usually the responsibility of health insurers to submit a policy amendment to the division that complies with any legislative changes that have been adopted. 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.

The mental health parity law became effective January 1, 2000, and required insurers to provide coverage in compliance with the law. However, it is unclear how well the coverage mandate is being implemented by insurers. One case of non-compliance and how it impacts consumers is discussed here.

Prior to an on-site audit covering January 1, 1999 through December 31, 2000, by the insurance department's Market Conduct Division, the company to be audited notified the division that it had not paid out-of-network claims in accordance with the mental health parity law from January 1, 2000 through October 1, 2000. One reason for this was because the company had never amended its health policy to provide the coverage required under the parity law. Although the company retroactively reimbursed enrollees for any claims erroneously denied back to the law's effective date, it is likely that some enrollees never even sought treatment because they did not realize that the new law effectively prohibited the provision of lesser coverage allowed in health plans before the parity law was adopted. This example illustrates that a more proactive approach by the division should be in place to ensure mandated benefits are available to health plan enrollees on the date the law become effective.

The committee believes that a consistent approach should be adopted by the division in informing health insurers of new or amended state mandates and recommends:

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.

As presented in the briefing report, total reported utilization review statistics show that although the number of utilization review requests overall (for physical and mental health) remained relatively stable from 1998 to 2004, denials for all services grew by more than 221 percent over the same period. Utilization review statistics for mental health showed a somewhat different picture – while requests specifically for mental health treatment were also fairly stable, denials actually decreased 81 percent from 2001 to 2004, the years in which data were required to be submitted. *Thus, while there are some limitations with the data as explained below, they do show that utilization review denials for mental health services have declined thereby increasing access to treatment, while requests for general health services have increased.*

Data limitations. The briefing report also noted that utilization review determination statistics reported by utilization review companies are self-reported. The department’s Market Conduct Division has frequently found during its examinations of utilization review companies that most had “erroneously reported utilization review information to the insurance commissioner.”⁵ *The committee found other problems with the data are:*

- *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 are reduced by the utilization review company, that is reported to CID as a denial);*
- *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.*

The committee believes accurate and more detailed utilization review information needs to be provided for two reasons. First, the Market Conduct Division should be analyzing this type of information to identify companies that may be denying particular types of service or treatment before beginning an audit. Second, although separate statistics are reported by managed care organizations for inclusion in the Consumer Report Card, the mental health statistics that are reported are originally generated by utilization review companies if the insurer “carves out” the mental health benefit. Since this information is included in the Consumer Report card even though the Market Conduct Division typically cites these companies for providing inaccurate

⁵ Susan F. Cogswell, Report to Governor M. Jodi Rell, Insurance and Real Estate Committee, Public Health Committee, Concerning the Regulation of Managed Care, March 1, 2005.

information, efforts should be made to ensure it is accurate. **Therefore, the committee recommends:**

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, or extension of stay);**
- **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. For example, one company provided only the number of complaints received, but no explanation of the action taken was included in the report, while another company listed a description of each complaint separately, along with whether it was justified. Neither of the companies calculated the ratio of complaints received to total enrollees.

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. Managed care report cards exist in more than 25 states, and many of these states also publish separate mental health cards or incorporate information about mental health plans into a single report card.

Responsibility for publishing the report card. The real key to ensuring that mental health benefits are administered fairly and consistently is to make comprehensive information publicly available. The program review committee examined the consumer education roles of both CID and the Office of Health Care Advocate (OHA) and found that while the insurance department’s focus is on protecting insured enrollees from unfair insurance practices through regulation of health insurers, the OHA’s focus is largely one of consumer advocacy. The mission of the office is:

to assist consumers with health care issues through the establishment of effective outreach programs and the development of communications related to consumer rights and responsibilities as members of managed care plans. One overriding desire will direct the Office of Healthcare Advocate: to provide consumer-friendly assistance to those who may be confused about health care in general and need help in working through various managed care issues.

The committee believes the analysis required for, and publication of the Consumer Report Card would be better located in OHA. Given that this would be one of the primary responsibilities of the office and not an add-on function to regulation of insurance, the committee believes the overall product would be improved. Furthermore, although Public Act 05-253 requires the insurance commissioner to develop a public education outreach program by January 1, 2006 to educate health care consumers about the various health care options in Connecticut, and to post it on its website, the committee believes that OHA will have to play a vital role in this effort. **Therefore, the committee recommends:**

C.G.S. Sec. 38a-478l 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.

Currently, OHA has a full-time staff of three – healthcare advocate, director of consumer affairs, and a secretary. A Deputy Director position was eliminated by executive action in 2003. (The office is located within the Connecticut Insurance Department for administrative purposes only.) The committee estimates that one additional staff would be needed by OHA to undertake the analysis, compilation, and publication of the report card given that most of the data is already reported to CID, and other states that publish similar documents could be used as existing models.

Contents of the report card. Connecticut law requires the submission of a variety of data by managed care organizations for possible inclusion into the report card, but does not mandate any particular measures be contained in the card. The law also gives the commissioner flexibility to “make any necessary modification in its form or substance.” The most current report card comparing managed care organizations includes for each insurer:

- the number of participating providers (primary care physicians, physician specialists in aggregate, hospitals, and pharmacies) located in each county;
- twelve quality measures (such as screening rates for certain diseases, and childhood immunization rates);
- overall utilization review statistics (reported annually by utilization review companies and managed care organizations separately);
- results of a company’s member satisfaction survey;
- customer service information;
- enrollment figures; and
- for health maintenance organizations, whether or not it is accredited by NCQA.

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. The limitations of such a card for consumers seeking to evaluate plans based on mental health services are clear. Physician specialists are reported in the aggregate, quality measures are focused on medical and/or physical health conditions, and none of the member satisfaction survey questions specifically deal with an enrollee's satisfaction with mental health services or ability to access an insurer's behavioral health network.

Although the Connecticut General Assembly in 2001 amended the law to require statistics concerning mental health utilization review determinations be reported separately, there was no requirement that those be included in the Consumer Report Card or any other CID publication. The committee believes the primary value in requiring utilization review companies submit this information is to make it publicly available, absent any affirmative analysis conducted by CID.

Evaluating network adequacy. The committee also found CID does not evaluate the adequacy of mental health care provider networks as part of its policy approval role or during market conduct examinations, although the Consumer Report Card does contain member satisfaction survey responses regarding access to treatment that are not specific to mental health.

Anecdotal information regarding "phantom networks for mental health providers" (i.e., providers listed in the company network materials given to enrollees but not accepting new patients) exists and should be of concern to regulators who are responsible for ensuring benefits that are covered in health policies can actually be obtained. However, given the limited state agency resources that are available to actually canvass multiple health plans' providers networks to verify their accuracy, the committee believes that publishing comparative mental health care provider ratios in the report card and adding a few additional questions on the member satisfaction surveys could prove useful for consumers.

To make the consumer report card a more useful tool for enrollees to compare mental health information on plans and their provision of services, **the committee recommends:**

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, or extension of stay, extension of inpatient stay, 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.

The committee believes incorporating mental health quality indicators into the existing Consumer Report Card would not require a large effort by insurers since most of the information is already submitted to the department. The first five measures required are already part of the HEDIS data. For insurers who are not NCQA accredited and do not participate in HEDIS, state law still requires they report similar data to CID. The insurance department, however, currently collects only those measures included in the Consumer Report Card.

The committee considered requiring a separate report card for mental health but decided that the measures should be integrated into the existing consumer report card for managed care organizations. This would alleviate any consumer concerns about confidentiality requesting a copy of the report card and make everything available in a single publication.

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. Furthermore, as better outcome measures are developed in the mental health field the report card may need to be revised. For example, "readmission rates" was a HEDIS measure at one time but NCQA

ceased collecting this statistic because it determined it was not effective at discriminating between health plans.

Public Act 05-289 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 act requires the office, in consultation with the Community Mental Health Strategy Board, to establish a process to provide ongoing communication among mental health care providers, patients, statewide and regional business organizations, managed care companies, and other insurers to assure: 1) best practices in mental health treatment and recovery; 2) compliance with state insurance laws governing (a) guaranteed availability and renewability of coverage, mental health parity, and discrimination based on health status, (b) standards concerning psychotropic drug coverage, and (c) coverage continuation for children with mental illness; and 3) the relative costs and benefits of providing effective mental health care coverage to employees and their families. The healthcare advocate is required to report to the public health and insurance committees by January 1, 2006, and annually thereafter on the implementation of the act.

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. **Therefore, the committee recommends:**

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

The briefing report described the process available to health plan enrollees and providers to resolve disputes with health insurers. State and federal laws require that HMOs, insurance companies, and self-insured employers operate an internal complaint and appeal process. Health care consumers also have multiple avenues to file complaints at the state agency level. Three state agencies respond to health care complaints, including CID, the Office of the Healthcare Advocate, and the Office of the Attorney General. Table III-1 shows the total number of complaints filed in 2004 and the number that were mental health related.

Table III-1. Total No. of Health Care Complaints Received in 2004.		
<i>State Agency/Office</i>	<i>Total Complaints</i>	<i># Re: Mental Health</i>
CID – Consumer Affairs Division	5,104	856
CID – Life and Health Division ¹	108	29
Office of the Attorney General	1,038	91
Office of the Healthcare Advocate	959	135
Total	7,209	1,111

¹ Conn. Statute 38a-478n gives enrollees covered under fully-insured managed care plans the opportunity to

appeal adverse determinations by a utilization review company with the Insurance Commissioner. The review is conducted by an independent organization and is administered by this division.
Source: LPR&IC Analysis.

As the table indicates the bulk of complaints is filed with the 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.*

Since CID is the agency that regulates insurance, it should be using this information to identify whether any patterns or practices exist by companies that are in violation of the law. In order to properly do this, CID needs to be aware of all the complaints being filed against health insurers by consumers, providers, or other employers. **Therefore, the committee recommends:**

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.

The committee believes it is to the consumer's benefit to have multiple avenues available to them to file a complaint, so no recommendation is made to centralize this function. However, it is crucial that the state regulatory agency – CID – be fully aware of the universe of health care complaints being filed by health plan enrollees against health insurers and whether those complaints are justified.

Complaint data should be closely tracked to detect potentially unfair practices and patterns and trigger regulatory action, if necessary. Requiring the compilation of health care complaint data from three different state agencies will ensure accurate reporting and ranking of health insurers by the department.

Study of Regulation of the Health Insurance 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 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. **Therefore, the committee recommends:**

The Legislative Program Review and Investigations Committee 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.

The last program review committee study of CID and its role in regulating the managed care market was performed in 1996. Thus, it has been several years since the department's activities have been examined in this area. There have been major changes in the managed care market since that time, including: the laws regulating the industry; consolidation of health care insurers; the types of health plans available; the increased use of "carve outs" for a number of health care benefits; the expanded use of utilization review companies; and shifts to self-funded health plans by employers. Given these changes, the committee believes this would be a timely study for the committee to undertake.

APPENDICES

APPENDIX A

1. Please identify your profession (i.e., type of license issued to you by the Department of Public Health):			
		Response Percent	Response Total
medical doctor (psychiatrist)	██████	12.8%	81
clinical psychologist	██████	12.8%	81
advanced practice registered nurse	█	4.9%	31
clinical social worker	██████████████████	41.6%	263
professional counselor	████	9.8%	62
marital and family therapist	████	10.1%	64
licensed alcohol and drug counselor		0.2%	1
certified alcohol and drug counselor		0.2%	1
none of the above (do not complete rest of survey. Click next and exit survey)	████	7.6%	48
Total Respondents			632
(skipped this question)			0

2. Please rate the effectiveness of the 1999 mental health parity law on:				
	Very Effective	Somewhat Effective	Not Effective	Response Average
Expanding access to mental health treatment	15% (54)	56% (198)	28% (99)	2.13
Expanding access to mental health providers	14% (47)	45% (154)	42% (145)	2.28
Improving the quality of mental health treatment	12% (40)	38% (131)	51% (176)	2.39
Reducing stigma associated with mental illness	11% (37)	44% (152)	46% (159)	2.35
Total Respondents				350
(skipped this question)				282

3. Based on your experience, how has the mental health parity law impacted:

	Improved	No Effect	Worsened	Don't Know	Response Average
the utilization review process	18% (64)	31% (108)	16% (55)	36% (125)	2.68
provider reimbursement rates	9% (31)	41% (143)	25% (87)	26% (91)	2.68
processing claims to providers	11% (37)	42% (147)	16% (57)	31% (108)	2.68
expanding provider networks	17% (59)	33% (115)	15% (53)	35% (122)	2.68
Total Respondents					351
(skipped this question)					281

4. How many years have you been in practice?

	Response Percent	Response Total
less than 5 years	14.3%	51
5 - 10 years	16.9%	60
10 - 20 years	23.3%	83
20 years or more	45.5%	162
Total Respondents		356
(skipped this question)		278

5. Estimate the number of patients you see in a typical week:

	Response Percent	Response Total
under 5 patients	7.1%	25
5 - 10 patients	11.1%	39
10 - 20 patients	27.6%	97
20 - 30 patients	28.2%	99
30 - 40 patients	13.4%	47
more than 40 patients	12.5%	44
Total Respondents		351
(skipped this question)		283

6. In what type of setting do you practice? (check all that apply)

	Response Percent	Response Total
private practice in the community	70.1%	249
clinic based	16.1%	57
hospital based	18.6%	66
Other (please specify)	18.9%	67
Total Respondents		355
(skipped this question)		277

7. If in private practice, do you work in a group practice or are you a solo provider?			
		Response Percent	Response Total
solo		77.2%	203
group		22.8%	60
Total Respondents			263
(skipped this question)			370

8. Do you employ administrative staff to handle:			
	yes	no	Response Total
billing and claims	41% (138)	59% (200)	338
utilization review	16% (51)	84% (267)	318
Total Respondents			336
(skipped this question)			296

9. If you employ administrative staff, please indicate the number you employ?	
Total Respondents	126
(skipped this question)	506

10. Do you specialize in a particular area of mental health treatment?			
		Response Percent	Response Total
no		52.3%	179
Yes (please specify the area)		47.7%	163
Total Respondents			342
(skipped this question)			292

11. Do you treat:			
	yes	no	Response Total
children	46% (147)	54% (172)	319
adolescents	74% (253)	26% (87)	340
adults	96% (333)	4% (15)	348
Total Respondents			352
(skipped this question)			280

12. Do you accept managed care insurance?			
		Response Percent	Response Total
yes		70.1%	244
no		29.9%	104
Total Respondents			348
(skipped this question)			286

13. Please indicate whether you belong to any of the following provider panels:

	yes	no	Response Total
Aetna	47% (138)	53% (157)	295
Anthem	67% (212)	33% (105)	317
Cigna	39% (115)	61% (180)	295
Connecticare	49% (142)	51% (150)	292
HealthNet	59% (184)	41% (127)	311
Oxford	48% (140)	52% (154)	294
Other	62% (161)	38% (100)	261
Total Respondents			327
(skipped this question)			305

14. Are you currently accepting new patients with insurance?

		Response Percent	Response Total
yes		55.1%	188
no		23.2%	79
depends on insurer		21.7%	74
Total Respondents			341
(skipped this question)			293

15. Have you ever declined to take on a new patient for treatment because the patient was insured by a particular company or covered by a particular plan?

		Response Percent	Response Total
yes		44.6%	153
no		55.4%	190
Total Respondents			343
(skipped this question)			291

16. If yes, provide the reason(s) for your decision (check all that apply):

		Response Percent	Response Total
too many claims denied		33.3%	56
claim reimbursement delays		47%	79
inadequate reimbursement		67.9%	114
contract difficulties		25%	42
difficult obtaining prior authorization		40.5%	68
poor customer service		42.3%	71
Other (please specify)		35.7%	60
Total Respondents			168

17. Please estimate the percent of your patients that have private insurance			
		Response Percent	Response Total
under 25 percent		23.6%	80
25 - 50 percent		15.9%	54
51 - 75 percent		19.8%	67
more than 75 percent		40.7%	138
Total Respondents			339
(skipped this question)			295

18. Do you place restrictions on the number or percentage of patients in your practice who are insured by particular companies?			
		Response Percent	Response Total
yes		18.2%	62
no		81.8%	279
Total Respondents			341
(skipped this question)			293

19. If yes, what are your reasons for limiting the number or percentage of patients insured by them? (check all that apply)			
		Response Percent	Response Total
reimbursement rate		74%	57
difficulty in obtaining prior authorization		48.1%	37
delays in claim reimbursement		48.1%	37
too many claim denials		42.9%	33
Other (please specify)		45.5%	35
Total Respondents			77
(skipped this question)			555

20. In your opinion, do individuals who have private insurance have adequate access to mental health care?			
		Response Percent	Response Total
yes		9.8%	34
no		31.5%	109
depends on insurer		18.2%	63
depends on individual's health plan		37%	128
Other (please specify)		3.5%	12
Total Respondents			346

21. How long does a new patient typically have to wait in order to get an appointment with you?

		Response Percent	Response Total
less than 3 days		22.2%	75
3-7 days		38.8%	131
8-14 days		17.8%	60
15-21 days		9.2%	31
more than 21 days		5.9%	20
Other (please specify)		6.2%	21
Total Respondents			338
(skipped this question)			296

22. What has been your experience with the utilization review process (i.e., obtaining prior authorization for patients)?

	Very Positive	Generally Positive	Generally Negative	Very Negative	Response Average
Experience	3% (9)	50% (166)	37% (122)	10% (34)	2.55
Total Respondents					329
(skipped this question)					303

23. How many telephone encounters per week do you and your staff have with utilization review companies concerning:

		Response Percent	Response Total
claims		96.8%	243
prior authorization		98.4%	247
Total Respondents			251
(skipped this question)			381

24. Rate your experience in obtaining prior authorization for patients who need the following mental health treatment:

	Not Difficult	Somewhat Difficult	Very Difficult	Don't Know	Response Average
inpatient admission	9% (29)	30% (95)	19% (61)	41% (129)	2.92
inpatient continued stay	2% (5)	13% (39)	32% (101)	53% (166)	3.38
partial hospitalization	6% (20)	31% (96)	21% (65)	41% (128)	2.97
intensive outpatient treatment	11% (33)	34% (106)	26% (80)	30% (94)	2.75
initial outpatient visits	62% (205)	22% (72)	5% (17)	10% (34)	1.63
additional outpatient visits	24% (79)	48% (156)	18% (59)	10% (34)	2.15
Total Respondents					328
(skipped this question)					304

25. How frequently have you altered the mental health treatment you gave to a patient because of the utilization review process?			
		Response Percent	Response Total
Frequently	██████████	16.3%	54
Occasionally	████████████████████	37%	123
Rarely	██████████	24.4%	81
Never	██████████	22.3%	74
Total Respondents			332
(skipped this question)			302

26. If you altered treatment, how did you alter it? (check all that apply)			
		Response Percent	Response Total
treated as inpatient instead of outpatient	█	3.2%	8
treated as outpatient instead of inpatient	██████████	24.1%	61
frequency of visits lessened	██	84.6%	214
treated in group therapy instead of individual therapy	██████████	12.3%	31
prescribed drugs instead of treatment	██████████	11.5%	29
changed medication	██████████	14.2%	36
Other (please specify)	██████████	18.2%	46
Total Respondents			253
(skipped this question)			379

27. In your experience, is there a difference in obtaining prior authorization for mental health treatment versus substance abuse treatment?			
		Response Percent	Response Total
yes	██████████	22.2%	72
no	██████████	14.2%	46
sometimes	██████████	17.6%	57
not applicable (don't treat mental health patients)		0.6%	2
not applicable (don't treat substance abuse patients)	████████████████████	45.4%	147
Total Respondents			324
(skipped this question)			310

28. Have you ever filed a complaint with the:

	yes	no	Respos Total
Connecticut Department of Insurance	15% (48)	85% (277)	325
Office of the Managed Care Ombudsman	15% (50)	85% (273)	323
Office of the Attorney General	14% (45)	86% (277)	322
Total Respondents			333
(skipped this question)			299

29. If yes, what was the subject of the complaint? (check all that apply)

	claim delays	claim denials	prior authorizatoin delays	prior authoization denials	other	Responder Total
Connecticut Department of Insurance	51% (24)	64% (30)	15% (7)	32% (15)	21% (10)	47
Office of the Manged Care Ombudsman	35% (17)	54% (26)	12% (6)	33% (16)	27% (13)	48
Office of the Attorney General	37% (17)	52% (24)	7% (3)	30% (14)	39% (18)	46
Total Respondents						81
(skipped this question)						551

30. If you filed a complaint, rate the overall performance of the department or office in resolving it?

	Very Effective	Somewhat Effective	Not Effective	Not Applicable	Respos Total
Connecticut Department of Insurance	13% (9)	22% (15)	34% (23)	30% (20)	67
Office of the Managed Care Ombudsman	15% (10)	36% (24)	23% (15)	26% (17)	66
Office of the Attorney General	30% (19)	14% (9)	22% (14)	33% (21)	63
Total Respondents					97
(skipped this question)					535

31. In general, are you satisfied that the claims you submit to insurers are paid on a timely basis?			
		Response Percent	Response Total
yes		15.5%	46
no		26.3%	78
depends on insurer		58.2%	173
Total Respondents			297
(skipped this question)			337

32. Please provide an estimate of the percent of claims submitted by you monthly for fully insured patients that are not paid within the 45 day statutory timeframe required by law:	
Total Respondents	227
(skipped this question)	405

33. What rate do you typically charge a self-pay patient for a 45 - 50 minute therapy session?			
		Response Percent	Response Total
less than \$40		4.3%	13
\$40 - \$49		1.3%	4
\$50 - \$59		3.3%	10
\$60 - \$74		11.8%	36
\$75 - \$89		12.2%	37
\$90 - \$100		18.8%	57
\$101 - \$125		18.4%	56
\$126 - \$149		9.5%	29
\$150 - \$174		12.5%	38
more than \$175		7.9%	24
Total Respondents			304
(skipped this question)			330

34. Please specify the range in the reimbursement rate you receive from health insurers for a 45 - 50 minute therapy session?	
Total Respondents	251
(skipped this question)	381

35. For patients with insurance, what is the average patient co-pay for a 45 - 50 minute individual therapy session?

		Response	Response
no co-pay	■	2.8%	8
less than \$5		0%	0
\$5 - \$10	■	9.6%	27
\$11 - \$20	■	51.4%	145
\$21 - \$30	■	19.1%	54
\$31 - \$40	■	3.9%	11
\$41 - \$50	■	3.5%	10
Other (please specify)	■	9.6%	27
Total Respondents			282
(skipped this question)			352

36. If you have any comments that you would like to provide to the committee concerning mental health parity, please add them below.

Total Respondents	169
(skipped this question)	463

APPENDIX B

Legislative Program Review and Investigations Committee

Request for Information: Mental Health and Substance Abuse Trends for Fully Insured Managed Care Plans Issued in Connecticut

1. Annual inpatient utilization rates from 1997 through 2004 for general health, MH/SA combined, MH only and SA only:

- Inpatient admissions per 1,000 enrollees
- Average length of stay
- Inpatient days per 1,000 enrollees
- Reason for admission (diagnosis) in aggregate

Rates of readmission within 30 days (from discharge date to readmission) for MH and SA (combined and separately)

Per Member Per Month (PMPY) Cost for:

- General health
- Mental health
- Substance abuse

2. PRI Staff will leave it up to your association on how best to define this category but it most likely will include such treatment as partial hospitalization and intensive outpatient

- encounters per 1,000 members
- encounters per 1,000 members by type of provider
- encounters per 1,000 by major diagnostic category

Per Member Per Month (PMPY) Cost for:

- General health
- Mental health
- Substance Abuse

3. Annual outpatient utilization rates from 1997 through 2004 for general health, MH/SA combined, MH only and SA only:

- encounters per 1,000 enrollees
- encounters per 1,000 enrollees by type of provider (2004 only)
- encounters per 1,000 by major diagnostic category (2004 only)
- encounters per 1,000 enrollees by type of visit:
 - evaluation
 - medical management
 - treatment/therapy
- Average number of visits for people receiving outpatient services

Per Member Per Month (PMPY) Cost for:

- General health
- Mental health
- Substance abuse

4. Behavioral Health Provider Network (2 points in time – pre-2000 and 2004)

Number of mental health/SA providers in network by type and by county:

- Psychiatrists
- Advance practice registered nurses
- Clinical psychologists
- Clinical social workers
- Marital and family therapists
- Professional counselors
- Alcohol and drug counselors

5. Top [10 or 15 or 20] medication prescriptions for mental illness for 1997 and 2004 (will leave to discretion of association to determine number) by:

- Total number written
- Total claims paid

6. Utilization Review for MH/SA Only (1997, 2001, 2004 – 3 years only)

- Name of UR company (if applicable)
- How many levels of internal appeal does your company have?
- Number of requests requiring utilization review
 - Number denied (i.e., a denial letter was issued)
 - Number appealed
 - Number reversed