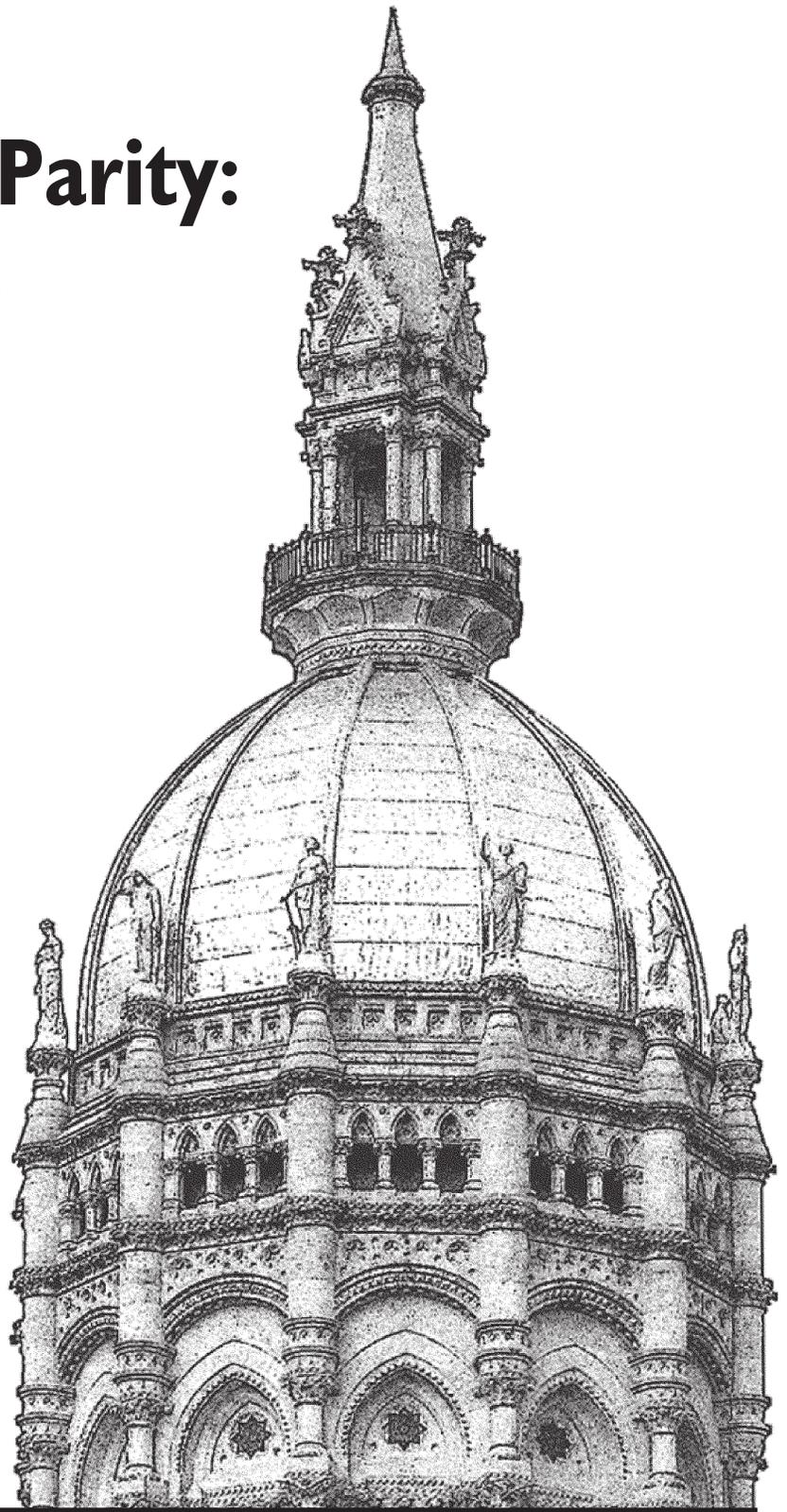


# Mental Health Parity: Insurance Coverage and Utilization

December 2005



**PRI**

**Legislative Program Review and  
Investigations Committee**

Connecticut General Assembly

**CONNECTICUT GENERAL ASSEMBLY  
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE**

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

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LEGISLATIVE PROGRAM REVIEW  
& INVESTIGATIONS COMMITTEE

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

DECEMBER 2005

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# Introduction

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## Scope of Study

The Legislative Program Review and Investigations Committee voted to conduct a study in April 2005 entitled Mental Health Parity: Insurance Coverage and Utilization. The review focuses on the implementation of Public Act 99-284, which requires health plan coverage for diagnosis and treatment of mental conditions place no greater financial burden on an insured individual than for physical conditions under the same policy beginning January 1, 2000. The law applies only to individual and employer-based fully insured health plans. 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 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, only one-third of Connecticut's population is covered by the law because as a state insurance mandate it does not apply to the three major public health insurance programs -- 1) Medicaid; 2) the medical portion of State Administered General Assistance (SAGA) 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).<sup>1</sup> Unless specifically noted, this report focuses only on fully insured commercial health policies.

The scope of the study was to evaluate the impact of 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 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. 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.

## Background

In Connecticut, a limited mental health parity law was first enacted in 1997, requiring parity for certain biologically based mental illnesses. A more comprehensive parity law was

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<sup>1</sup> 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 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).

adopted in 1999 and required health insurers to implement the provisions of the law beginning January 1, 2000.

Prior to the adoption of parity laws in Connecticut and elsewhere, health plans placed limits on the scope of mental health services through differing co-pays for mental versus physical conditions, limiting the number of annual mental health visits, and imposing differing annual and lifetime monetary caps for mental versus physical conditions. States began adopting mental health parity laws during the 1990s. The objectives of these laws were threefold:

- making mental health and substance abuse benefits equal to physical health benefits within a health plan (private health insurance plans typically provided lower levels of coverage for the treatment of mental illness than for the treatment of other illnesses);
- reducing the financial burden for consumers of mental health services and their families by prohibiting higher co-pays and limits on benefits than those in place for medical services; and
- reducing the stigma associated with these services by recognizing that benefits should be equal.

### **Study Limitations**

It should be noted from the outset that this study does not examine the issue of mental health parity for all Connecticut citizens. The state's mental health parity law, the focus of this study, only applies to private fully insured health plans and the people they cover, an ever decreasing percentage of the state's population. There are several limitations to conducting a thorough evaluation of the mental health parity law in Connecticut. First, there is a wide variety of health care plans that offer a mixture of benefit structures that apply to both physical and mental health conditions. Evaluating parity with so many variations of plan offerings is problematic. Second, the only official state regulatory agency overseeing the mental health parity law is CID, and the activities conducted by it in specifically measuring mental health parity are somewhat limited, as will be discussed in this report.

Because the state's role is limited, information and publicly maintained data are incomplete. Mental health parity is a legal requirement, not a specific program that a state agency operates, so very little detailed information is collected at the state level on how the parity law affects mental health care utilization and costs in the private sector.

Although it has been almost six years since insurers were required to provide mental health benefits on par with other medical benefits, the committee found it difficult to evaluate the 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 the lack of data collected at the state agency level, 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 voluntarily cooperated and provided data to the committee. 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. Despite these constraints, the data allowed some insight into compliance with and impact of the law.

## **Summary of Findings and Recommendations**

*Based on 1997 to 2004 data submitted by the three insurers, the committee found that utilization of mental health services increased by every standardized measure examined. Furthermore, insurer 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. In addition, practitioners noted three areas that are of concern to them including:

- low provider reimbursement rates for mental health treatment;
- disruptive and time-consuming utilization reviews to determine medical necessity and appropriateness of treatment; and
- limited behavioral health provider networks which may result in inadequate access to care.

Most of those interviewed, including mental health providers and advocates, and insurance industry representatives, expressed a general belief that the parity law has had a positive impact on the provision of 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 care 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 an analysis of 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. Currently, these complaints are received and acted on by three different state agencies.

## **Report Organization**

The report contains seven chapters. The first chapter gives an overview of the history of mandated mental health benefits in Connecticut and summarizes Connecticut's 1999 parity law. Chapter Two provides an overview of the participants in the private insurance market, including the number of health insurers offering fully insured health plans and the number of mental health providers licensed by the Department of Public Health (DPH). Chapter Three describes the regulatory activities of CID in ensuring insurers comply with the parity law, analyzes utilization review statistics that are reported to the insurance department by managed care organizations, and evaluates consumer mental health complaints.<sup>2</sup> Chapter Four describes two other state offices that handle health care complaints – the Office of the Attorney General and the Office of the Healthcare Advocate -- and contains an analysis of those involving mental health.

Chapter Five summarizes the results of the committee's mental health provider survey. Chapter Six 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. Finally, the last chapter 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.

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<sup>2</sup> Utilization review is the prospective or concurrent assessment of the medical necessity and appropriateness of treatment given or proposed to be given to an insured person. A particular treatment strategy may be denied or restricted on grounds that it is not "medically necessary" or "medically appropriate." These terms are not defined by state law or regulation. However, utilization review companies annually submit data to CID on the numbers of utilization review requests performed for mental health treatment, denials of treatments, and appeals of those decisions filed by enrollees.

## **Agency Response**

It is the policy of the Legislative Program Review and Investigations Committee to provide agencies subject to a study with an opportunity to review and comment on the recommendations prior to publication of the final report. Appendix F contains responses from the Connecticut Insurance Department, the Office of the Healthcare Advocate, and the Office of the Attorney General.

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## Mental Health Parity Laws: History and Current Status

Before the adoption of Connecticut's parity law, in 1997, broadened in 1999, mental health benefits required under state law were limited. Then, state law required group insurance policies, at a minimum, to provide:

- 60 days of inpatient mental health care annually;
- up to 120 days of outpatient care; and
- annual benefits of \$2,000 per year for major medical policies.

Individual health care policies were not subject to those requirements.

As mental health advocates began drawing attention to the discrepancies in treatment coverage between mental health and physical health insurance, states began to require that mental health and/or substance abuse treatment be covered in the same way as other medical care. It is important to note that mental health parity laws do not guarantee unlimited benefits, but only require equivalent coverage to that provided for physical disorders within a specific plan. Therefore, it is still possible for an individual to exhaust his or her entire mental health coverage because many insurance policies have aggregate monetary ceilings for all types of benefits. Thus, individuals who reach these benefit ceilings would need to forego care or pay out-of-pocket for continued treatment because coverage would have expired.

**Federal Mental Health Parity Act.** At the federal level, the Mental Health Parity Act (Public Law 104-204) was adopted in 1996 and became effective January 1, 1998. The law applies to employers with 50 or more employees, including self-insured companies. It requires that lifetime and annual reimbursement caps for mental health services, if provided be equal to those for physical health services. However, the law *does not require* mental health coverage to be provided in health insurance plans, nor does it prohibit employers from eliminating mental health benefits. Under the federal act, mental health benefits do not include substance abuse or chemical dependency treatment.

To help soften any dramatic cost increases to employers, the act exempts plans that incur a premium increase of one percent or more. Companies seeking an exemption from the law must show proof of the one percent or greater premium increase based on real data from actual claims and administrative cost for six months. Federal rules require all employers and insurance companies affected by the law to comply with its requirements for at least six months before applying for an exemption.

While the policy objective is to achieve mental health parity in coverage, the federal law does not change or prohibit certain insurance practices such as:

- setting separate co-pays and deductibles for mental health services; or

- limiting or denying mental health services to enrollees whose needs are not defined as "medical necessary."

The act contained a sunset provision originally set for September 30, 2001, but has been extended to December 31, 2005.

**Other states.** States began enacting parity laws in the 1990s, and to date more than 33 states have passed mental health parity laws. However, there is considerable variation in the scope of the laws enacted by individual states. Some states mirror the federal mandate, others limit the insurance coverage to a specific list of biologically based mental illnesses, and still others, like Connecticut, provide for broad coverage of almost all mental illnesses, including alcohol and substance abuse. Appendix A provides a comprehensive list of states with mental health parity laws and describes the scope of each state's law.

### **Connecticut's Mental Health Parity Laws**

The Connecticut General Assembly initially enacted a parity law in 1997, which applied only to certain biologically based illnesses, and then broadened the law in 1999.

**Biologically based parity laws (P.A. 97-99 and P.A. 97-8, June Special Session).** The legislature adopted two separate acts in 1997 – one requiring mental health parity in group health insurance policies, the other in individual health insurance policies. Public Act 97-99, as part of a broader bill regulating managed care, required mental health parity for coverage of biologically based mental or nervous conditions in fully insured group health insurance contracts that was at least equal to the coverage provided for medical or surgical conditions. The law originally required parity with respect to eight conditions: (1) schizoaffective disorder; (2) major depressive disorder; (3) bipolar disorder; (4) paranoia; (5) other psychotic disorder; (6) obsessive-compulsive disorder; (7) panic disorder; and (8) pervasive developmental disorder or autism. A ninth condition, schizophrenia, was added under P.A. 97-8, June Special Session (JSS).

If covered medical or surgical conditions in a policy were subject to a copayment, deductible, coinsurance, or lifetime benefit maximum, biologically based mental or nervous conditions would also be subject to the same requirements. Furthermore, the law did not affect coverage for other types of mental illnesses -- which under existing state law only applied to group health policies -- still subject to existing state-mandated limitations. The act allowed health insurers to perform utilization review to determine "medical necessity" for treatment for biologically based mental or nervous conditions if, under the plan, medical or surgical conditions had to satisfy this requirement.

P.A. 97-8, (JSS) extended the parity requirement to health insurers offering individual policies and the covered conditions were the same as those for group health insurance. It also revised the definition of "biologically based mental illness" by specifying that the eligible mental disorders were those defined in the most recent edition of the American Psychiatric Association's Diagnosis and Statistical Manual of Mental Disorders (DSM), the manual used for diagnosing mental illness.

**Expansion of mental health parity (P.A. 99-284).** By 1999, pressure to enact a more comprehensive mental health parity law resulted in the adoption of Public Act 99-284. The act expanded the requirement for mental health parity in fully insured group *and* individual health insurance contracts by eliminating the biologically based criteria and instead applying parity to all mental health conditions as defined by the DSM. Thus, parity is required for all mental or nervous conditions by prohibiting health policies that contain terms, conditions, or benefits that place a greater financial burden on an insured for care of mental health conditions than for care of medical, surgical or physical conditions.

*Conditions covered and excluded.* The act applies to mental disorders defined in DSM-IV, which was published in 1994 and is the most recent edition of the Diagnostic and Statistical Manual of Mental Disorder. While mental health conditions as defined in the DSM are covered, the act specifically excludes the following from coverage:

- mental retardation;
- learning, motor skills, communication, and caffeine-related disorders;
- relational problems; and
- other conditions that may be the focus of clinical attention that are not otherwise defined as mental disorders in the manual.

*Inpatient coverage.* In addition to specifying the covered conditions, the act eliminates the limitations on inpatient care for the treatment of substance abuse in group health insurance policies (previously a 45-day limit). The act also requires parity for the treatment of substance abuse in individual and group plans because it is a mental disorder under the DSM.

*Policies affected.* The parity requirements apply to individual and group health insurance policies offered in Connecticut beginning January 1, 2000. The implementation requirement affects policies offered by HMOs, managed care organizations, and indemnity insurers that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, and (4) hospital or medical services.<sup>3</sup> The act also requires the HUSKY Plan, Part B – a publicly funded health plan that covers uninsured children who are poor but not eligible for Medicaid -- to comply with the provisions of the act.

*Provider reimbursement.* The act mandates individual insurance policies provide insurance reimbursement to certain allied health care providers' with authority to diagnose and treat mental or nervous conditions, already required under group policies. These include:

- licensed clinical psychologists;
- licensed clinical social workers;
- social workers certified as independent before October 1, 1990;
- licensed marital and family therapists or those certified before October 1, 1992; and

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<sup>3</sup> Disability income, accident-only, long-term care, hospital confinement, specified accident, Medicare supplement, limited benefit coverage, and specified disease policies are not covered under the act.

- licensed or certified alcohol and drug counselors (extended to both group and individual policies in this act).

People with master's degrees in social work or marital family therapy may receive insurance reimbursement when their services are provided in a child guidance clinic or a residential treatment facility under the supervision of a psychiatrist or other physician, psychologist, or licensed social worker or marital and family therapist who is also eligible for reimbursement.

Private insurance reimbursement is also required for outpatient services rendered in: (1) a nonprofit community mental health center as defined by the Department of Mental Health and Addiction Services; (2) a licensed nonprofit adult psychiatric clinic operated by an accredited hospital; or (3) a residential treatment facility. Services in these facilities must be provided under the supervision of a: psychiatrist; licensed psychologist; licensed marital and family therapist; or a licensed clinical social worker who is eligible for reimbursement. Services must also be within the scope of the license issued to the center or clinic by the Department of Public Health.

*Utilization review.* Although the law *prohibits* health care plans from imposing more restrictive limits on coverage for mental disorders, it is important to note that health plans may still subject all types of care (mental, medical, surgical, and physical) to utilization review. Thus, while a plan may not impose discriminatory limits on the care of mental disorders in its policies, it may make judgments about the level or extent of any given recommended treatment that will be covered under the plan. Judgments about a particular treatment strategy may be denied or restricted on the grounds that it is not “medically necessary” or “medically appropriate.” State law requires both an internal and external appeal process be available to enrollees who are denied services, which are discussed in Chapter Three.

## Chapter Two

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### A Profile of Mental Health Services: Consumers, Providers, and Insurers

#### Consumers

**Mental illness defined.** Mental illness is the term that refers collectively to all diagnosable mental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). A mental disorder is characterized by alterations in thinking, mood, or behavior that contribute to individual and family distress, impaired functioning, loss of freedom, and heightened risk of pain, disability, or death. The degree of mental illness is distinguished by differences in symptoms, duration, severity, and prognosis depending on the specific diagnosis.<sup>4</sup>

The diagnosis of mental disorders is more difficult than diagnosis of general medical disorders, since there is no apparent injury or lab test that can identify the illness. The diagnosis of mental disorders must instead rely on patient's reports of the intensity and duration of symptoms; signs from their mental status examination; and clinician observation of their behavior including functional impairment. These clues are grouped together by the clinician into recognizable patterns known as syndromes. When the syndrome meets all the criteria for a specific diagnosis, it constitutes a mental disorder.<sup>5</sup>

Mental disorders are common in the United States. An estimated 22.1 percent of Americans ages 18 and older—about 1 in 5 adults—suffer from a diagnosable mental disorder in a given year.<sup>6</sup> In Connecticut, according to a 2005 report published by the Lieutenant Governor's Mental Health Cabinet, there are nearly 600,000 Connecticut adults who have symptoms of mental illness. Of these, about 135,000 have a serious mental illness and another 66,000 suffer from severe and persistent mental illness. Although no definite numbers exist for the number of Connecticut children with mental illness, estimates range from 87,500 to 125,000 children and youth who also exhibit a mental health condition.

#### Mental Health Providers

There are several different types of mental health providers who practice in a variety of settings, including inpatient acute-care and psychiatric hospitals, partial hospitalization and day treatment programs, outpatient clinics, and community private practices. There are a number of elements to treatment including psychotherapy, pharmacological therapy, and peer-to-peer support.

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<sup>4</sup>Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*, Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

<sup>5</sup> Ibid.

<sup>6</sup> Regier DA, Narrow WE, Rae DS, et al. The de facto mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, 1993; 50(2): 85-94.

Based on 2005 data, there are over 10,000 mental health providers licensed or certified by the Department of Public Health in Connecticut (the department only collects information on who is licensed, which may differ from who is actively practicing). Table II-1 shows clinical social workers are by far the largest type of mental health providers in the state, accounting for 44 percent of all mental health providers in 2005. Of the provider categories depicted in the table, only psychiatrists can legally prescribe medications. However, individuals can also receive mental health care services, particularly in the form of pharmacological therapy, from their primary care physicians, and never visit a mental health provider. In addition, some advanced practice registered nurses specialize in mental health treatment, although DPH does not capture that number. Thus, the numbers of practitioners providing treatment for mental health conditions are most likely underrepresented in the table.

<b>Table II-1. Licensed and Certified Mental Health Providers in CT.</b>									
<b>Type</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
Physicians identifying psychiatry as specialty	n/a	n/a	n/a	n/a	n/a	1,426	1,467	1,466	1,460
Clinical Psychologists	1,371	1,396	1,437	1,463	1,472	1,448	1,550	1,597	1,611
Clinical Social Workers	3,502	3,605	3,738	3,874	3,912	3,924	4,263	4,408	4,463
Prof. Counselors <sup>1</sup>	--	369	1,084	1,311	1,310	1,303	1,226	1,254	1,138
Marital & Family Therapists	536	607	638	817	815	785	717	708	675
Licensed Alcohol & Drug Counselors <sup>2</sup>	--	--	524	545	549	542	575	585	593
Certified Alcohol & Drug Counselors <sup>3</sup>	--	--	352	303	279	255	260	248	251
<b>Total</b>	--	--	--	--	--	9,683	10,058	10,266	10,191
n/a – not available									
<sup>1</sup> Licensure program began in 1998									
<sup>2</sup> Licensure program began in 1999									
<sup>3</sup> Certification program began in 1999									
Source: Department of Public Health									

## Health Insurers

There are 27 managed care organizations licensed to operate in the state that are required to comply with the mental health parity law - six Health Maintenance Organizations (HMOs) and 21 managed care indemnity insurers.<sup>7</sup> In total, these companies accounted for written premiums of \$4.3 billion dollars in 2003 for fully insured plans issued in Connecticut.

HMOs and other health insurers may offer individual and/or group health policies. As noted in Chapter One, the mental health parity law applies only to certain fully insured health policies – those that cover basic hospital expense, basic medical-surgical expense, major medical, hospital or medical service plan contracts, and hospital and medical coverage provided to subscribers of a health center. The insurance department does not track the number of policies offered within each of these broad categories.

<sup>7</sup> There are also 11 indemnity companies that write only student insurance policies, which are also subject to state mandates.

According to CID, almost all of the health policies offered in Connecticut, whether through an HMO or a managed care indemnity insurer, include a network of providers and a utilization review component. An employer may offer a range of plans and let its employees choose among them, or select a specific plan. As an example, the State of Connecticut offers its employees a choice between three different health insurers, each of whom offers three types of health plans:

- point of service plan (POS) - health care services are available both within and outside a defined network of providers; no referrals are necessary to receive care from participating providers; health care services obtained outside the defined network may require pre-authorization and are reimbursed at the rate of 80% of the plan's allowable cost after the annual deductible has been met;
- point of enrollment plan (POE) - health care services are covered only from a defined network of providers; no referrals are necessary to receive care from participating providers; health care services obtained outside the defined network may not be covered; or
- point of enrollment gatekeeper plan (POE-G) - health care services are available only from a defined network of providers; a primary care physician (PCP) must be chosen to coordinate all care; referrals are required from the PCP for all specialist services.

Depending on the plan selected by an employee, he or she may be required to contribute different amounts to cover the difference in premiums. Also, there may be different deductibles, coinsurance requirements, and co-pays depending on the plan selected and whether out-of-network providers are being used. This example illustrates that, in terms of mental health parity, even when health benefits are compared among state employees, there could be differences in benefit levels in terms of what employees pay (in premiums and co-pays) because of the plan selected and how services are accessed. (See Appendix B for more detail.)

**Enrollment trends.** Managed care organizations must submit certain statistics to CID annually, including enrollment statistics. Table II-2 shows the overall number of enrollees in managed care fully insured and self-insured plans since 1997. The reason for the 41 percent growth rate between 1997 and 2003 according to insurance department staff is because indemnity insurers are not required to report enrollment figures and some managed care organizations may not have understood the initial reporting requirements. Given these data limitations, most of the enrollee growth can be attributed to the increase in the number of individuals enrolled in self-insured health plans, which almost doubled since 1997. There was only a 17 percent increase in enrollment in fully insured plans over the same time period.

<i>Plan Type</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>
Fully-Insured	1.1	1.1	1.4	1.5	1.5	1.4	1.3
Self-Insured	.6	.6	.6	1.0	.9	1.1	1.1
Total	1.7	1.7	2.0	1.5	2.4	2.5	2.4

Source of Data: CID Consumer Report Cards 1997 – 2003.

In particular, self-insured health plans have gained in popularity among large employers and labor unions. These groups create a pool of money from employers and employee contributions and then pay for the health care services of their members from this fund. Typically, self-insured plans will hire a third party administrator (TPA) to handle all administrative tasks including processing claims, ensuring payments are made, and conducting utilization review for medical necessity. Often employers contract with health insurers to act as a TPA for all health care claims.

One possible reason for the increase in the number of enrollees in self-funded health plans is that employers are seeking to avoid state health insurance mandates (not just for mental health, but all mandates) and other state insurance regulation since most of these plans are regulated by the U.S. Department of Labor and not by the state insurance department. Another plausible reason for employers opting to self-fund is because it can be more cost-effective for the employer as it eliminates profits paid to health insurers for assuming the financial risk.

It is important to note that the federal Mental Health Parity Law (discussed in Chapter One) would apply to some of those employers who self-fund in Connecticut. Furthermore, nothing prohibits employers who self-fund from providing the same level of benefits than those mandated at the state level. This benefit information, however, is unavailable because it is not collected by any state agency.

# Chapter Three

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## Connecticut Insurance Department

Responsibility for ensuring that health insurance policies provide state mandated health benefits rests with the Connecticut Insurance Department, the agency charged with regulating the insurance industry in Connecticut. 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 the insurance department is to ensure broad compliance by health insurers with Connecticut laws and regulations, as well as the terms and conditions stated in health care contracts.

In order to understand how the department monitors compliance with the mental health parity law, the committee focused its review on three of the nine divisions within the department – Life and Health, Market Conduct, and Consumer Affairs. The major activities of these divisions, as they relate to how the department enforces the mental health parity law, are described in this chapter.

### Life and Health Division Major Activities

The Life and Health Division reviews and approves all group and individual health insurance policy forms, plans, applications, riders, and endorsements to ensure compliance with Connecticut insurance law. In addition, the division also:

- publishes an annual Consumer Report Card comparing managed care organizations across a variety of measures although none specifically relate to mental health coverage;
- licenses utilization review companies;
- administers the external appeals process;
- oversees the expedited review process for managed care organizations;<sup>8</sup> and
- processes requests for rate increases on individual and group accident and health policies (since mental health costs are not usually separated out in rate filings, this activity is not discussed in this report).

**Health insurance policy approval.** A key function performed by the division is approving health care policies. Each managed care contract offered in Connecticut must contain several provisions, including:

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<sup>8</sup> Connecticut law requires an expedited review process if an enrollee has been admitted to an acute care hospital and the attending physician determines that the enrollee's life will be endangered or serious injury could occur if the patient is discharged or treatment is delayed. The attending physician may transmit a request for an expedited review and if a response is not received within three (3) hours from when the request was made, it is deemed approved. CID oversees this process.

- eligibility requirements;
- statement of co-pays and deductibles;
- benefits and exclusions;
- termination provisions;
- grievance procedures;
- conversion and extension of benefits; and
- out-of-area benefits, if any.

Before division staff will approve a policy, they ensure that the policy language is not deficient in any of the areas noted above and that it contains explicit language concerning any mandated covered benefit, such as mental health parity. The division staff ensure that language mirrors statutory requirements and no exclusions or limitations are noted in the policy that are contrary to law. The division staff use checklists (one for group, another for individual policies) while reviewing a policy to make sure all mandated benefits are stated in the policy (see Appendix C).

Typically before a policy is approved, there is considerable correspondence between division staff and staff employed by the health insurance company regarding compliance with Connecticut statutes and regulations. The focus of the correspondence is to require the insurer to add, delete, or modify specific policy language to ensure it conforms with all legal requirements.

*Policy amendments.* If the Connecticut General Assembly adopts a new state health insurance mandate, it is the responsibility of the health insurer to be aware of any new requirements and file a policy amendment with the division for approval and notify its enrollees of any coverage changes. The division has, on occasion, sent out a bulletin to insurers to clarify coverage requirements, but it is not routine practice.

*Copayment limits.* For several years, CID has administratively set the maximum allowable amount of copayments that individual and group health plans can require for certain health care services (some of which would include mental health). The division staff review policies to ensure compliance with the limits, which are shown in Table III-1. The limits would apply to mental health services, including specialist office visits, emergency room visits, and inpatient hospitalizations.

**Consumer information.** State law requires health insurers to provide each enrollee with a detailed plan description that must contain a summary of benefits including: pre-authorization and utilization review procedures; utilization review statistics; the number, types, specialties, and geographic distribution of providers; procedures on filing a grievance; description of covered emergency services; the use of drug formularies; telephone numbers for obtaining additional information; notification procedures when an enrollee's primary care physician is no longer in the network; procedures for obtaining referrals to specialists; status of the National Committee for Quality Assurance (NCQA) accreditation; enrollee satisfaction information; and procedures on protecting confidentiality.

<b>Table III-1. Copayment Limits Allowed by CID (revised as of March 2002).</b>		
<i>Service</i>	<i>Prior Limit</i>	<i>Revised Limit</i>
Primary Care Physician Office Visit	\$20	\$30
Specialist Office Visit	\$40	\$45
Urgent Care Visit	\$75	\$75
Emergency Room Visit (assumes co-payment waived if admitted)	\$75	\$150
Outpatient Surgery	\$200	\$500
Inpatient hospital	\$500/admission	\$500 per day up to \$2,000/admission
High Cost Diagnostic Test	\$0	\$200
Source: CID		

Generally, health plan enrollees are responsible for understanding the terms of their health coverage or the need to contact their personnel office or the health insurer’s 1-800 number to speak to a member service representative about any questions. However, because a stigma still exists in obtaining mental health treatment, an employee may be reluctant to ask his or her employer for additional information. Often, it falls to the mental health provider or his or her staff to be knowledgeable about various restrictions or limitations of a patient’s health plan.

*Annual Consumer Report Card published by CID.* The Life and Health Division collects information submitted annually by all managed care organizations and publishes a consumer report card, which permits consumer comparison across organizations. For each insurer, the report card includes:

- 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 by utilization review companies annually);
- results of member satisfaction survey;
- customer service information;
- enrollment figures; and
- whether or not the HMO is accredited by NCQA<sup>9</sup>;

The report card does not contain any specific information on mental health utilization rates or numbers of mental health providers belonging to various health plan networks.

**Licensing utilization review companies.** Under Connecticut law, CID is responsible for annually licensing all utilization review companies. Managed care organizations can perform utilization review directly or can “carve out” certain benefit areas, such as mental health, meaning that a separate company specializing in behavioral health performs utilization review

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<sup>9</sup> 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.

for the MCO. As of December 31, 2004, there were 120 utilization review companies licensed in Connecticut; 46 of those performed utilization review for behavioral health.

Utilization review is used by all major health plans to assess medical necessity and appropriateness of treatment and to contain costs. By law, companies are required to use written clinical criteria and review procedures, known as medical protocols, which are established and periodically evaluated and updated with appropriate input from practitioners. Each health plan determines which services are subject to utilization review. Examples of treatments or services subject to utilization review include:

- inpatient hospitalization for physical and mental health treatment, including length of hospital stay;
- inpatient and outpatient surgery;
- participation in partial hospitalization and intensive outpatient mental health programs;
- outpatient treatment (usually after a certain number of visits have been exhausted); and
- outpatient services, such as physical therapy and chiropractic care.

***Utilization Review: Process and Procedures.*** The conduct of utilization review can be a contentious issue in the mental health field and is of concern to many providers, advocates, and consumers of mental health services. Providers argue that having to justify treatment plans to utilization review companies is a very time-consuming process and the reimbursement is inadequate for the amount of time they must spend, particularly for patients who need hospitalization or several treatment sessions. Providers also are frustrated because the initial point of contact with a utilization review company may be an individual with limited mental health training, who does not have the authority to override strict medical protocol. Managed care organizations, on the other hand, believe that conducting utilization review is an important quality assurance function, and also helps contain costs by preventing medically unnecessary and/or inappropriate care.

***Utilization review requirements.*** A mental health care provider will usually know if obtaining prior authorization is required before providing treatment services or admitting a person to a hospital for inpatient mental health services depending on a patient's health insurance. When a provider submits a utilization review request, the utilization review company makes its decision on whether to deny or approve the request based on information submitted by the treating practitioner and uses its protocols to determine the medical necessity and appropriateness of the proposed treatment. In general, the provider or the enrollee can call the utilization review company via an 800 number to determine if the procedure will be covered, and, if hospitalization is involved, the number of days preauthorized.

If a provider or enrollee does not obtain prior authorization before providing treatment, and the treatment is retrospectively considered medically necessary, he or she can still be penalized (the lesser of \$500 or a 50 percent reduction in payment is allowed by state regulation, but more stringent penalties in a provider's contract with the managed care organization would prevail).

*Internal appeals process.* Under Connecticut law, utilization review companies must meet certain statutorily established timeframes and procedural requirements for providing notification of its determinations. Enrollees or providers on behalf of enrollees must be notified of decisions made by the utilization review company within two business days of receipt of all information. Any determination not to authorize an admission, service, procedure or extension of stay must be in writing and include: 1) the principal reasons for the determination; 2) the procedures to initiate an appeal of the determination; and 3) the procedures to file an external appeal with the CID commissioner.

Figure III-1 shows the process that enrollees must follow to appeal utilization review denials. The first step is known as an internal appeal, when an enrollee must first dispute the utilization decision to the health plan (if the health plan has carved out mental health and substance abuse services, the appeal may be handled by the utilization review company). As shown in the figure, most health plans have two levels of internal appeal.

For internal appeals, the utilization review company by law has 30 days to notify the enrollee of its decision. The company also must:

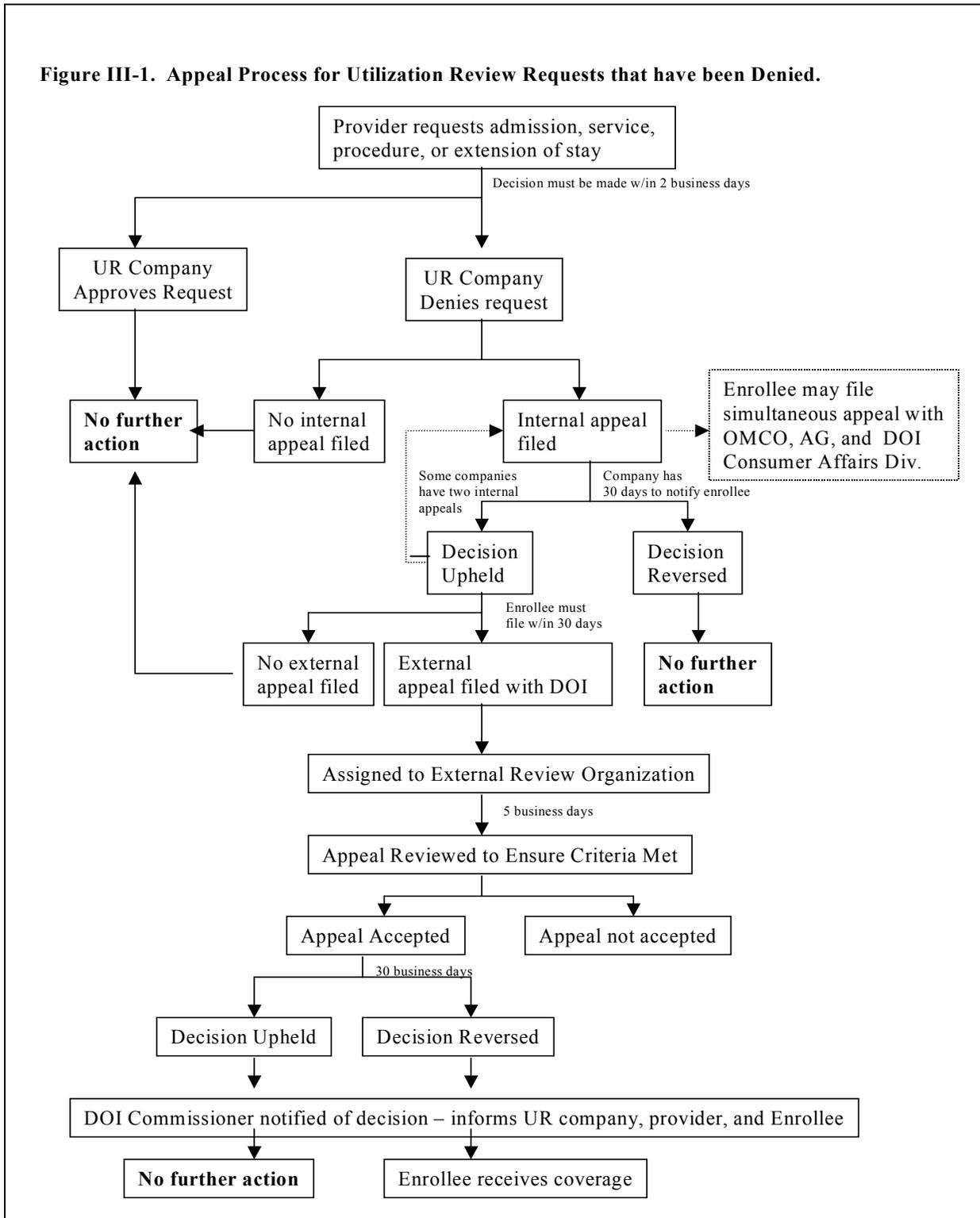
- have a licensed practitioner of the medical arts make the determination;
- use written clinical criteria and review procedures that are periodically evaluated and updated with involvement from practitioners;
- have a specialist who is a specialist in the field related to the condition that is the subject of the appeal review the case if the reason not to preauthorize is based on “medical necessity” ;
- ensure the review is conducted by a practitioner, (or under the authority of a practitioner) who has a current CT license from DPH; and
- maintain documentation of the review for CID commissioner verification.

***Utilization Review Statistics: An Analysis.*** 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 stay. Companies must also report to CID the number of preauthorization requests that are denied; the number appealed; and the appeal outcome. In 2001, the law was amended to require utilization review determinations related to mental or nervous conditions be reported separately from all other determinations.

The program review committee conducted an analysis of the utilization review statistics reported annually by each licensed utilization review company. It is important to note there are several caveats attached to the analysis of the data including:

- the statistics are self-reported and not audited by CID;
- there is no category for partial utilization review denials (e.g., if the number of visits a provider requests was reduced by the utilization review company, that would be reported to CID as a denial);
- only aggregate statistics are reported; and

**Figure III-1. Appeal Process for Utilization Review Requests that have been Denied.**



- self-funded plans under ERISA and the state HUSKY B program are included in the statistics that are reported because companies do not separate out utilization review decisions of enrollees from fully-insured plans from those in self-funded plans.

Table III-2 shows statistics reported by utilization review companies on the total number of utilization reviews requested, denied, appealed, and reversed on appeal since 1998 through 2004 (for both physical and mental health). The table shows the number of utilization review requests increased until 2002 and then decreased by almost one-quarter in two years. The number of denials grew from slightly more than 28,000 to over 90,000 (221 percent) over the seven years examined, with the largest increases occurring between 1998 and 1999, and 2003 and 2004. Conversely, the table shows the number of appeals decreased over time, with 5,216 (19 percent) of denials appealed in 1998 and only 4,719 (5 percent) in 2004. Of those appealed, between 35 and 45 percent are ultimately reversed.

<b>Calendar Year</b>	<b>UR Requests</b>	<b>Denials</b>	<b>Appeals</b>	<b>Reversals</b>
1998	808,004	28,105	5,216	1,836
1999	908,576	64,586	4,837	1,928
2000	915,492	74,721	4,509	1,971
2001	951,421	69,086	4,026	1,582
2002	1,003,665	48,676	4,580	2,040
2003	907,233	63,858	4,936	2,342
2004	832,469	90,223	4,719	2,139

Source: CID

Table III-3 shows the number of utilization review requests in Connecticut specifically for mental/nervous conditions from 2001, the date that companies were statutorily required to report these figures to CID separately. In contrast to Table III-2, utilization review denials decreased 82 percent over the four years examined. In 2004, only 3 percent of requests received were denied compared to 15 percent in 2001. Reasons for this trend may be because many health insurers liberalized their prior authorization policies, allowing for a set number of treatments (usually between eight and 20 therapy sessions) before a provider would be required to obtain prior authorization. In addition, it is possible that because the mental health parity law mandated coverage for mental disorders defined in DSM-IV, health insurers covered more types of conditions and more individuals sought mental health services without having to undergo prior authorization.

<b>Calendar Year</b>	<b>UR Requests</b>	<b>Denials</b>	<b>Appeals</b>	<b>Reversals</b>
2001	177,879	27,558	639	207
2002	156,672	13,887	706	279
2003	208,696	6,195	521	157
2004	161,987	4,970	679	176

Source: CID

Table III-3 also shows that although small numbers of enrollees actually appeal adverse decisions, the number of appeals has been increasing relative to the number of denials. In 2001, 2 percent of denials were appealed compared to almost 14 percent in 2004. However, the percentage of decisions in favor of the appellant has been declining. Slightly more than one-quarter of the utilization review denials were reversed upon appeal in 2004 down from one-third in 2001.

Figure III-2 compares the percent of mental health utilization review requests to all requests in Connecticut. Overall, since the separate data on utilization review decisions became available in 2001, mental health utilization review requests comprise between 16 and 23 percent of all requests.

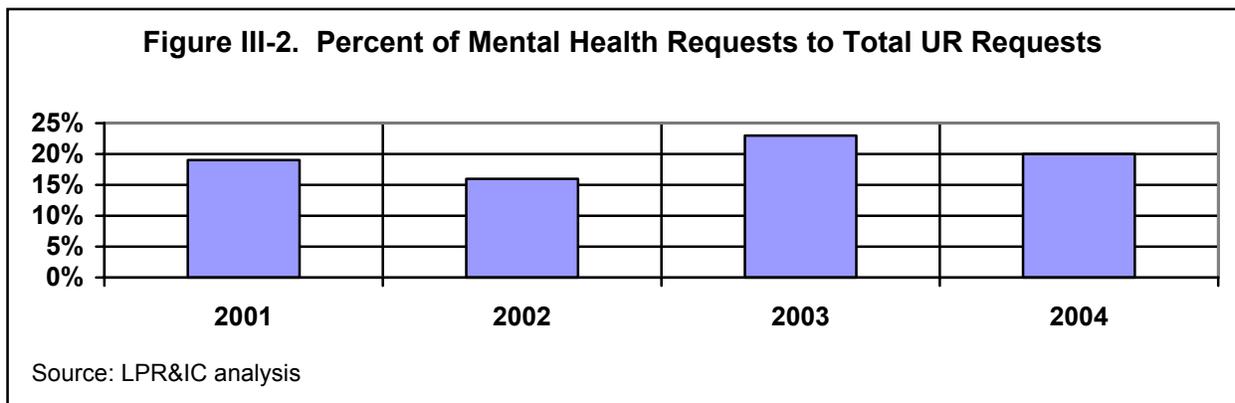


Figure III-3 shows the number of utilization review requests that were denied by mental health and non-mental health requests. As shown in the figure, the number of denials for mental health treatment has dropped from 15 percent to 3 percent between 2001 and 2003 and appears to have leveled off; in contrast the number of denials for non-mental health treatment rose five percent between 2002 and 2003.

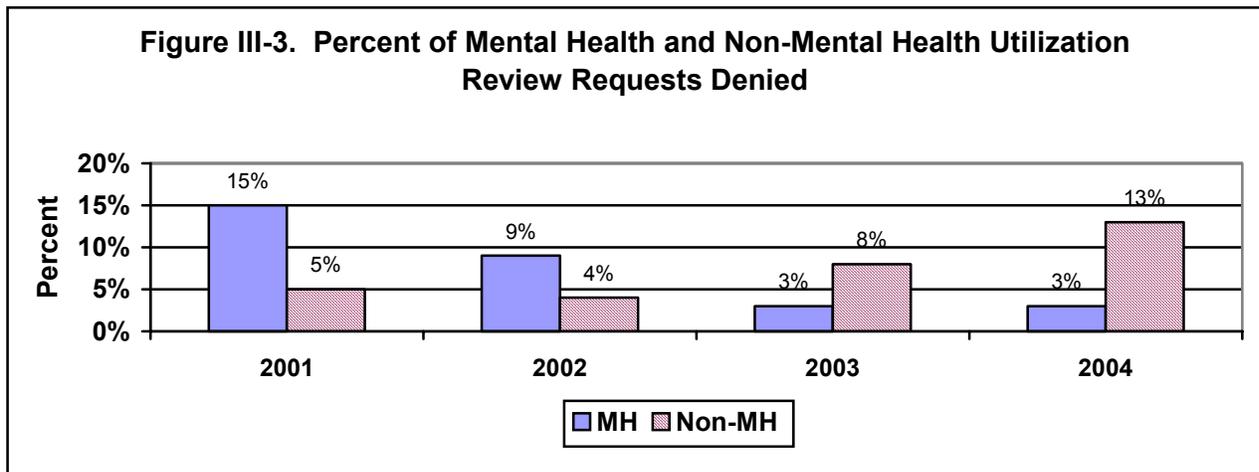


Figure III-4 shows the percent of denials appealed for mental health treatment has steadily risen since 2001 and is at its highest level in 2004, while appeals for non-mental health treatment is at its lowest. In 2001, the number of non-mental health utilization review decisions appealed was four times greater than mental health utilization review denials. Given that the number of utilization review requests for mental health treatment has decreased since 2001 (see Figure III-3), possible reasons for the increase in appeals may be that individuals in need of mental health services or providers on their behalf are more aware of the external appeal process and are willing to pursue this avenue to try and obtain services.

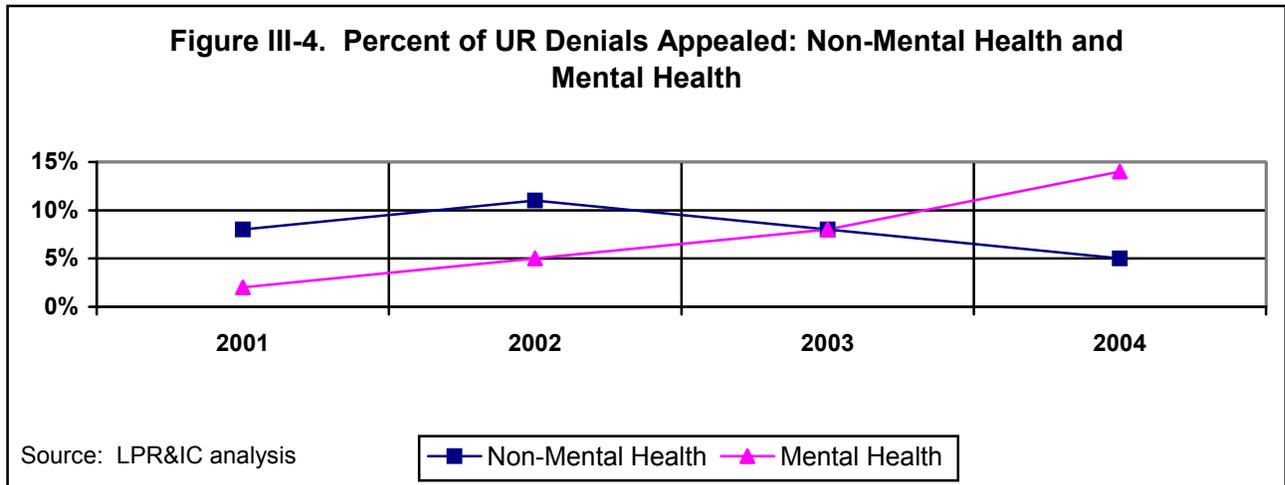
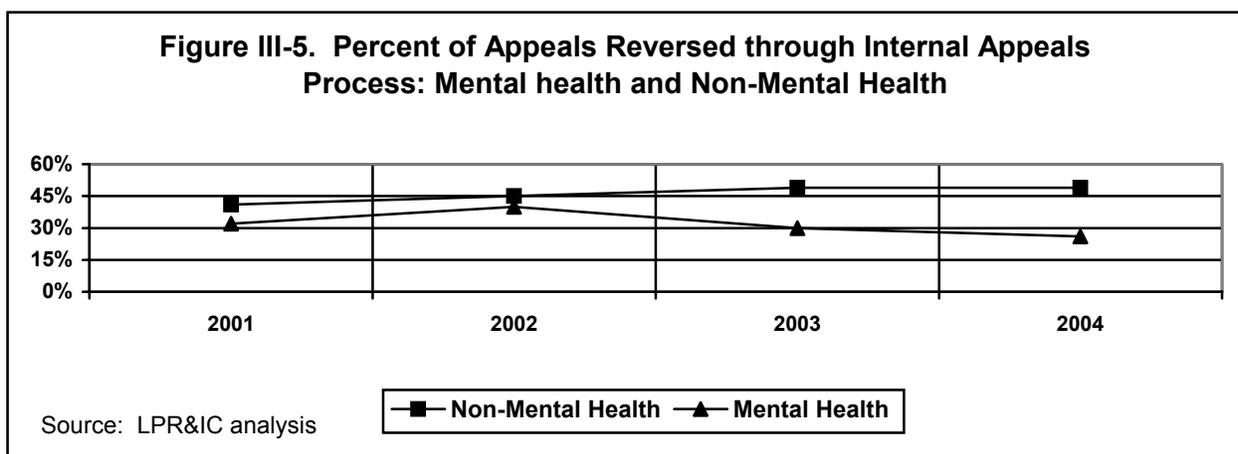


Figure III-5 compares the percent of appeals reversed during the internal appeal process. (Insurers are not required to report at what level of appeal a decision was reversed or upheld if they have more than one level). In 2004 almost 50 percent of the denial decisions were reversed on appeal for physical conditions, compared to less than 30 percent of MH appeals were reversed.



As noted above, if an individual (or his or her provider) appeals a denial and is unsuccessful under the internal appeal process, he or she may file an external appeal with the CID commissioner. Furthermore, an enrollee or provider at any point in the process may

simultaneously complain to the Department Of Insurance's Consumer Affairs Division, the Office of the Attorney General Health Care Advocacy Unit, or the OHA. These agency roles are discussed in the next chapter.

**CID external appeal process.** Another important function of the Life and Health Division is to oversee the external appeals process. Connecticut law (C.G.S. Sec. 38a-478n) gives enrollees who are covered under fully insured managed care plans the opportunity to appeal denials by their utilization review companies with the commissioner of insurance. To be eligible for the external appeal process the following requirements must be satisfied:

- the internal appeal process must be exhausted (any utilization review company acting on behalf of a health plan is required to provide the enrollee with written notification that the internal appeal process is exhausted);
- a "Request for External Appeal" form must be received from an enrollee by the insurance department within 30 days of receiving the written notification that the internal appeals have been exhausted;
- the individual must have been actively enrolled in a health care plan at the time the service was requested as well as when the service was provided;
- the external appeal may be used only for a service or procedure that is covered in the contract;
- the denial of medical treatment or services must be based on "medical necessity"; and
- the appeal cannot be for workers' compensation claims, "self-insured" plans, Medicaid, Medicare or a Medicare Risk program.

Requests for external appeals may be filed for retrospective claims denied when a service that was not subject to prior approval is denied as not "medically necessary" when the claim is submitted.

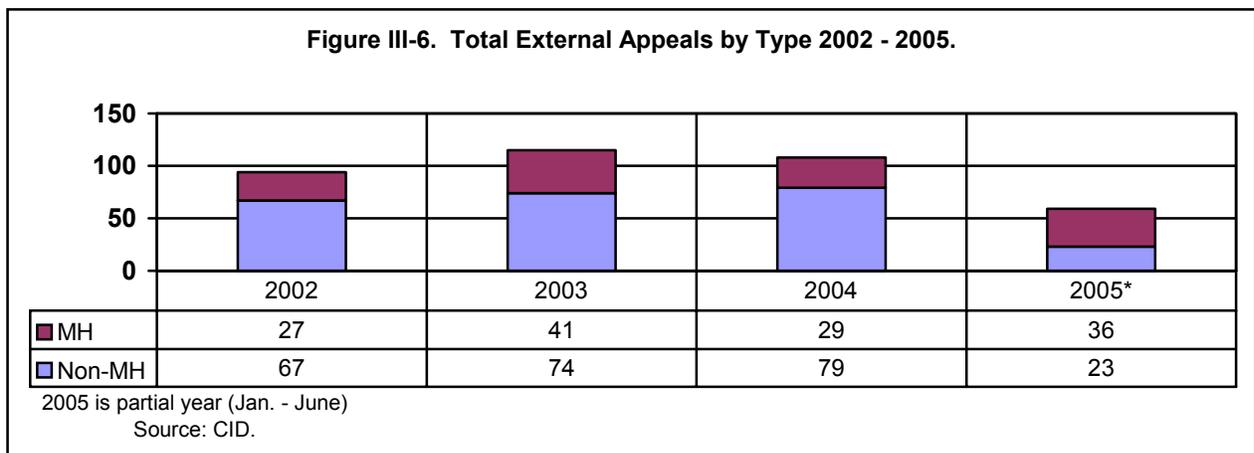
Referring back to Figure III-1 on page 20, if the insurance department receives a request for an external appeal, it is assigned to one of three external appeal organizations under contract with CID. The organization reviews the request and determines, based on the above criteria, whether it will be accepted for a full review. Reasons that a request would be rejected include: the request was sent in too late; the service was not covered under the individual's health plan; the appeal did not involve a determination of medical necessity; or the health insurance company's internal appeal process was not exhausted. If the appeal is accepted for a full review, a decision is rendered within 30 business days. The organization can reverse, revise, or uphold the decision of the utilization review company.

The external review must be performed by a provider who is a specialist in the field related to the condition that is the subject of the appeal. The commissioner must accept the decision of the external appeal organization and the decision is binding. The reviewing provider may take into consideration:

- pertinent medical records;
- consulting physician reports;

- practice guidelines developed by the federal government, national, state or local medical societies, boards or associations; and
- clinical protocols or practice guidelines developed by the utilization review company or managed care organization.

*External appeal statistics.* Data on external appeals are only available electronically from CID since 2002. Figure III-6 shows total external appeals filed with the insurance department categorized as involving a non-mental health or mental health issue, by calendar year. Overall, with the exception of 2005 (only a partial year of data), there were more external appeal requests for mental health. This is expected given that a higher percent of utilization review requests are denied for medical treatment than there are for mental health treatment (see Figure III-3).



As noted above, not all external appeal requests received by the department are ultimately accepted for review by the external review organizations. Figure III-7 shows the vast majority of appeals involving issues of mental health are accepted for review.

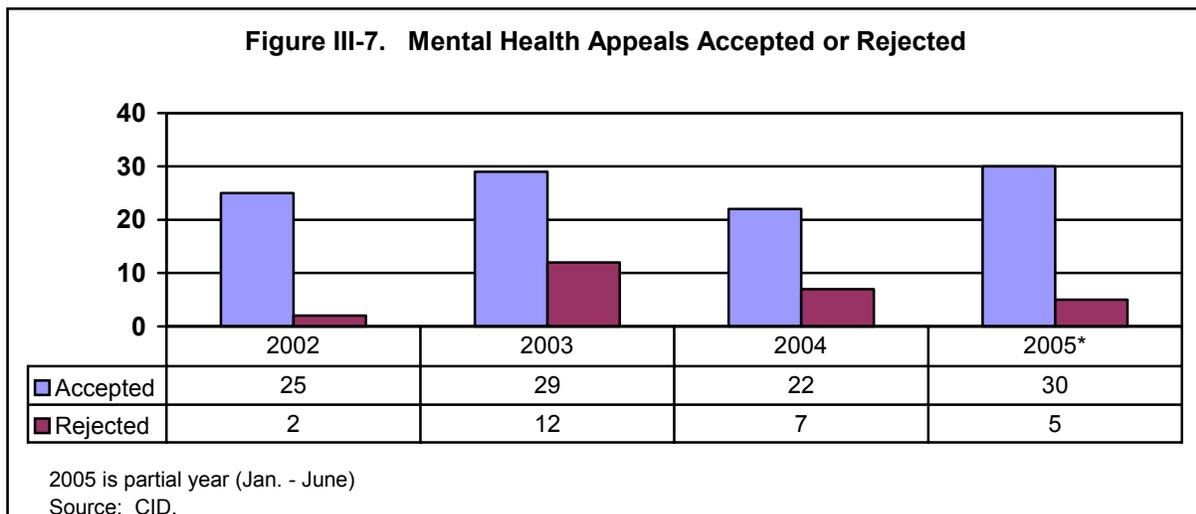
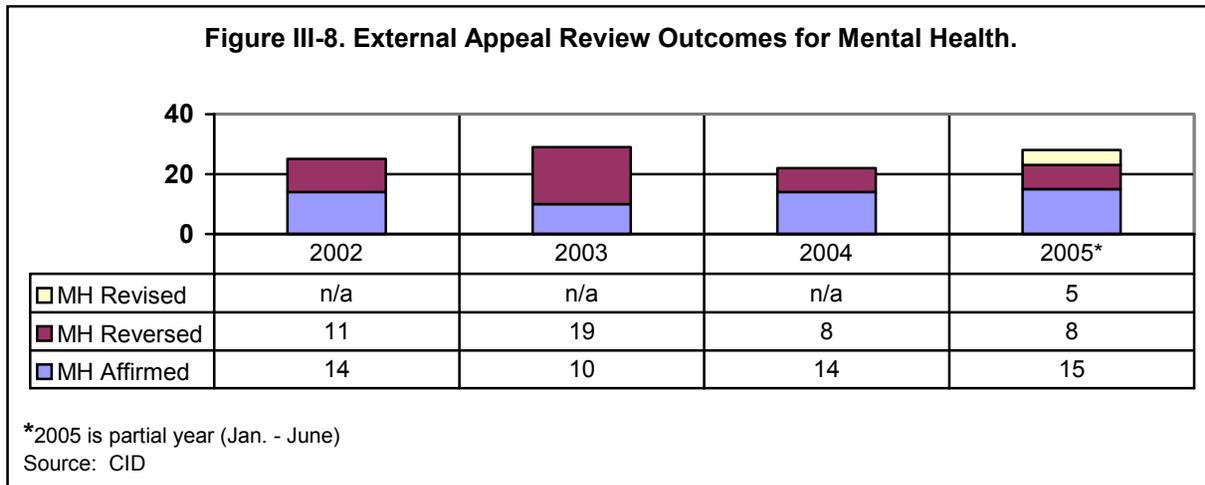


Figure III-8 compares the outcomes of the external review for cases involving mental health. The majority of decisions made by utilization review companies, with the exception of those appealed in 2003, were affirmed by the external review organizations. In 2002, 56 percent of utilization review company decisions were affirmed, 35 percent in 2003, and 64 percent in 2004. In 2005, the department created a third category, “revised,” that allowed external review organizations to issue more flexible decisions by permitting partial rulings in favor of the appellant or company (such as requiring only partial payment for disputed coverage).



### Consumer Affairs Division

The CID Consumer Affairs Division receives, reviews, and responds to complaints from state residents concerning insurance and also serves as a mediator in claim disputes to determine if statutory requirements and contractual obligations within the commissioner’s jurisdiction have been met. The division also 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.

Although the division responds to complaints regarding any type of insurance (e.g., auto, property/casualty, etc.), it has a separate Health Insurance Unit responsible for reviewing all complaints involving managed care and utilization review companies. The division maintains a database for all complaints received. Table III-4 compares the total number of health care complaints received by the Health Care Unit to those specifically involving mental health issues since 2002, the last year data are available.

Year	All Complaints	MH Complaints	% of Total
2002	7,093	369	5%
2003	4,182	602	14%
2004	5,104	856	17%
2005 (Jan. - June)	1,574	151	10%

Source: CID

The committee found the vast majority of health care complaints involving mental health issues are from health care providers or consumers complaining about denial and slow claim payment practices. Since 2002, there were a total of 1,978 mental health complaints in the database that contained the source of and the reason for the complaint. Most of the complaints (90 percent) concerned claims practices with 50 percent of them from insured individuals and 40 percent from providers.

Of the 1,766 complaints involving unfair claims practices, 72 percent were resolved in favor of the consumer or provider. The two most common resolutions in the database were claims settled (707 complaints) or claims settled with financial interest (560 complaints). Other possible outcomes included insufficient information provided, company position upheld, and policy not in force at time of claim.

In terms of the 156 complaints concerning utilization review, the database indicates that: the division provided information or an explanation to the complainant in 98 of the cases (63 percent); 40 cases were justified (26 percent); 8 cases the health insurer voluntarily agreed to reconsider (5 percent); and in 10 cases there was no action taken.

It is clear from the database that this division is not responding to many complaints concerning mental health utilization review concerns. However, CID is not the only state agency that accepts and responds to health care complaints. Both the Office of the Attorney General Health Care Advocacy Unit, and the Office of Healthcare Advocate also receive and respond to health care inquiries and complaints. The complaint handling activities of these two entities, as they relate to mental health parity, are discussed in the next chapter.

## **Market Conduct Division**

The Market Conduct Division's major function is to protect policyholders by detecting patterns and practices that indicate a company is operating contrary to laws or regulations. Claims settlement, cancellation, and pricing practices are closely investigated. The behavior of an insurance company in the marketplace in pricing its product, advertising, claims handling, and underwriting are all facets of a company's market conduct.

In terms of health insurance, the focus of the market conduct examination is different depending on whether the division's review is of a health insurer or a utilization review company. Market conduct examiners analyze health insurer claims data by targeting those that are paid and denied to determine inappropriate denial of claims. In addition, the division evaluates claims paid to determine if they were paid within the 45-day statutory timeframe. Only claims paid under fully insured health plans are examined. The division takes corrective action if deficiencies are found.

The division also has a utilization review compliance program to examine the functions of utilization review companies licensed by the department. Through the program, the division examines data on all licensed utilization review companies through annual surveys and performance of on-site as well as desk audits. The objective of the program is to protect the rights of health plan participants by determining if the companies licensed to perform utilization review are operating in compliance with the law.

The Market Conduct Division examines utilization review companies to determine if the companies are:

- operating in compliance with all statutory requirements, including timeliness of decisions and notification requirements;
- adhering to confidentiality laws; and
- using appropriate medical personnel when rendering utilization review decisions.

The division reviews company protocols and procedures used to render utilization review decisions to ensure they are in written form, periodically updated to reflect changes in medicine and statute, developed with local input from appropriately licensed medical professionals, and made available to providers upon request. Division staff do not evaluate the appropriateness of protocols or if it they were applied correctly.

In addition, examinations of utilization review companies track the percentage of denials, appeals, and overturned decisions to identify any trends or patterns, especially for a specific benefit or procedure. If the overturn rate is significant, the department can and has taken corrective action. In general, if the overturn rate is 50 percent or greater, this will automatically trigger a review and if this rate is between 25 and 50 percent, the division will look more closely to see if there is a specific procedure that is problematic.

A written report is issued at the conclusion of the examination that identified any compliance deficiencies and remedies needed. Since 2000, the division has annually reviewed about four companies specific to mental health services, except in 2003 when the division targeted nine companies for review. A review of these reports found that the most frequent exceptions noted by the division for improvements or modifications of utilization review company activities involved:

- failure to comply with the statutory requirements for timely notification of the outcomes of determinations and appeals;
- failure to maintain documentation evidencing that all denials of certification were issued in writing;
- erroneous reporting of utilization review information to the insurance commissioner; and/or
- lack of proper appeal language included in the letter to the enrollee.

## **Summary**

Most of the activities of CID are not focused on ensuring the provision of mental health coverage is in accordance with the parity law, which are only a minor part of the department's broader responsibilities in regulating the health insurance industry and managed care. Although some information has been statutorily required to be reported to the department on utilization review specific to mental health, it is unaudited and not published in any of the consumer guides. Furthermore, no utilization or claim data are collected by any state agencies that would allow for measuring the levels of mental health treatment over time.

## Chapter Four

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### **Other State Agencies Receiving Mental Health Care Inquiries and Complaints**

There are multiple avenues available to consumers and providers if they have a complaint against a health insurer or utilization review company. As shown in the last chapter, the Department of Insurance directly handles some complaints through its Division of Consumer Affairs while the Life and Health Division administers the external review appeal process for complaints involving adverse medical necessity determinations. Two other state agencies -- the Office of Attorney General and the Healthcare Advocate -- also receive health care complaints. An analysis of the complaints received by each of these agencies is provided in this chapter.

#### **Office of the Attorney General**

On November 10, 1997, the attorney general announced the formation of a Health Care Fraud/Whistleblower Division. Responsibilities under this division were expanded in 1998 to include a Health Care Advocacy Unit. The Health Care Advocacy Unit consists of three staff (two attorneys and a paralegal) who assist consumers and health care providers by resolving disputes with managed care companies. The unit advocates on behalf of patients, including participating in the internal appeal process and helping enrollees write complaint letters to insurers and utilization review companies.

According to the Office of the Attorney General, its authority derives from its broader consumer protection authority. The AG unit is different from CID because it accepts all complaints from Connecticut consumers regarding health care coverage, including those from enrollees of self-funded plans.

The unit maintains a database of the complaints it receives and uses it primarily for case tracking purposes. There are three important caveats associated with it. First, not every case was entered into the system, particularly in the earlier years (the database dates back to 1998), although unit staff believes the majority of cases are captured. Second, many of the cases in the database contain specific descriptions of each complaint and outcome so that much of the information could not be aggregated for analytical purposes by program review committee staff. Further, even when there was a category that could be aggregated, there were so many choices conclusions were difficult to make (there are 66 choices for “subject” and some of categories overlap). Finally, some information was not filled in and therefore not enough information could be gleaned to include in the analysis. Given these limitations, the number of mental health cases identified by program review committee staff are most likely underrepresented in the analysis below.

Altogether there were a total of 4,366 complaints in the unit database from 1998 through June 2005 but case dispositions were missing in 1,526 cases. The “subject” category identified 167 cases as “mental health” complaints and almost all of these concerned “medical necessity” decisions. An additional 173 complaints that were classified in other subject categories were reassigned by program review committee into the mental health category (but retained the original assignment as a subcategory) for a total of 340 mental health complaints. The

reclassified complaints concerned issues of medical necessity; late claim payments; denial of claim (after a service or treatment was provided); or benefit design disputes (whether coverage existed for a specific service or treatment). Case dispositions were missing in 166 of these cases.

### **Office of the Healthcare Advocate**

The Office of the Healthcare Advocate (formerly the Managed Care Ombudsman) was created in 1999 via passage of Public Act 99-284, "An Act Concerning Managed Care Accountability." The office has a full-time staff of three – the advocate, director of consumer affairs, and a secretary. A Deputy Director position was eliminated by executive action in 2003 although the office was recently given the authority to hire a Legislative and Administrative Advisor, expected to start in April 2006. This position will be responsible for legal work, research, legislation, regulation, and administrative policy for the agency. The anticipated start date is April 2006. The office is located within the Connecticut Insurance Department for administrative purposes only.

The office was created to promote and protect the interests of covered persons under managed care health plans in Connecticut. The office staff:

- assist consumers in making informed decisions when selecting a health plan;
- help consumers resolve problems with their health insurance plans; and
- identify issues that may require legislative remedies.

The office has no enforcement authority but can refer complaints to the Department of Insurance for regulatory action.

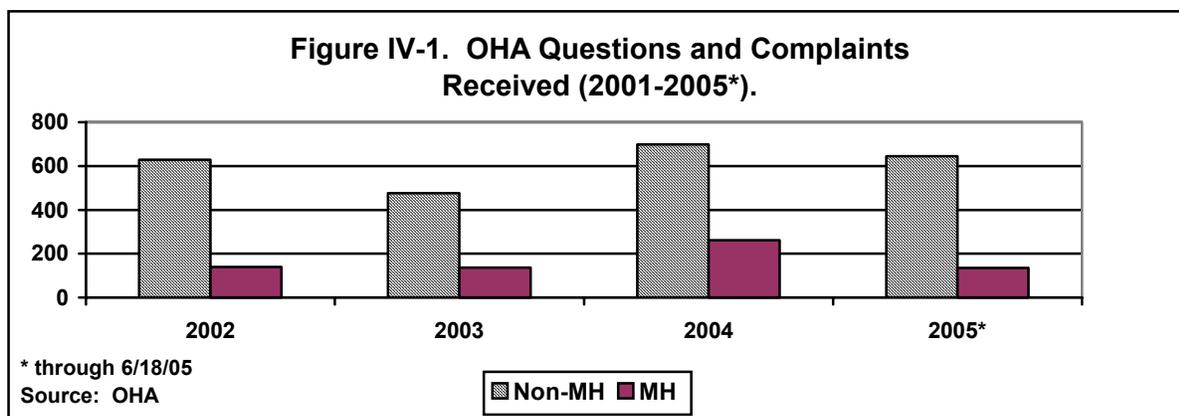
A major responsibility of the office involves educating consumers about their rights and informing them about how to advocate on their own behalf when they have problems or concerns about their managed care health plans. The office answers questions and assists consumers in understanding and exercising their rights to appeal a denial of a benefit or service made by the managed care plan. The office does not usually handle complaints from individuals in self-funded health plans, but will provide additional information to the complainant and/or refer them to the U.S. Department of Labor.

Based on a recommendation in the Lieutenant Governor's Mental Health Cabinet Report, additional responsibilities were given to the office under Public Act 05-280. This act requires OHA, in consultation with the Community Mental Health Strategy Board, to establish a process to provide ongoing communication among mental health care providers, patients, state-wide 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 ombudsman is required to report to the public health and insurance committees by January 1, 2006, and annually thereafter on the implementation of the act. As of January 2006, a Mental

Health Parity Work Group has been convened and has held six meetings. A report on the group’s activities to date was submitted to the public health and insurance committees at the beginning of January.

The Office of the Healthcare Advocate maintains a database of inquiries and complaints it receives. Information is separately maintained on inquiries and complaints received from individuals enrolled in self-funded health plans and these are excluded from the analysis presented below.

Figure IV-1 compares the number of non-mental health consumer questions and complaints received to those involving a mental health insurance issue since 2002, the last year for which data was available electronically. Overall, OHA has experienced a 25 percent increase -- from 2002 to 2004 -- in the number of questions and complaints it handles. The majority of inquiries and complaints received by the office involve non-mental health issues. However, the mental health inquiries and complaints are growing at a much faster rate – an 86 percent increase from 2002 to 2004 compared to only a 3 percent increase in non-mental health issues. Further, the number of mental health complaints for the first half of 2005 already equaled those received in 2002 and 2003.



Since 2002, the office has received a total of 673 questions and complaints concerning mental health insurance coverage. There were 32 possible categories to choose from in the database identifying the “type of issue.” Program review committee staff reclassified the data contained in these categories into seven broader categories, shown in Table IV-1. The table shows those involving utilization review, and billing and claims denials are the two most common.

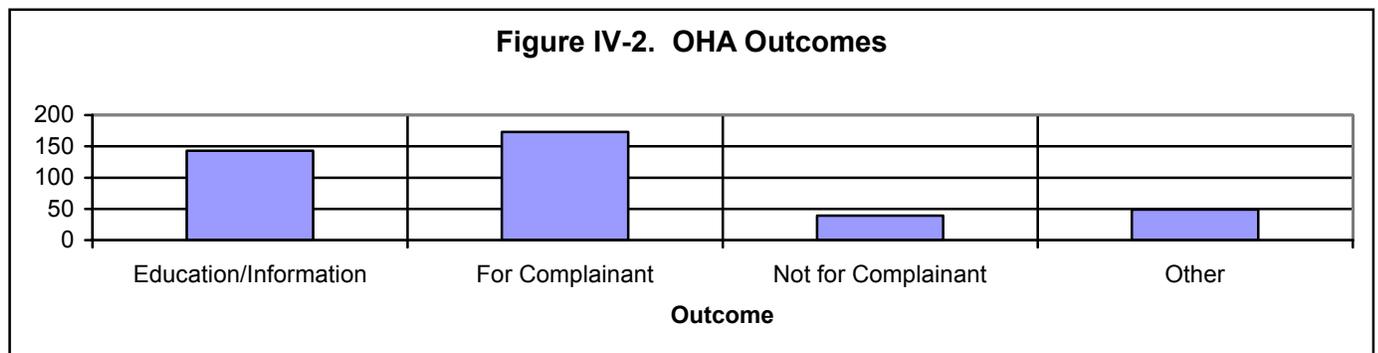
The database used by the healthcare advocate to capture inquiries and complaints contains 15 outcome categories. Committee staff collapsed these categories into four broader outcome categories, shown in Figure IV-2. Outcome data were available for only 404 of the 673 cases.

The committee specifically examined outcomes for utilization review, and billing and claim denial complaints. There were 237 utilization review complaints received by OHA: 95 (40 percent) had no final outcome entered in the database; 69 cases (17 percent) were resolved in

favor of the complainant, 49 cases (21 percent) resulted in information being provided, and 24 cases had other outcomes including no further contact by complainant. There were 179 complaints about billing and claims denial of which 70 cases had no outcome information, 70 cases were resolved in favor of the complainant, education was provided in 21 cases, and 18 had other outcomes.

<i>Type of Issue</i>	<i>Frequency</i>	<i>Percent</i>
Benefit Design (Coverage)	87	13%
Billing and Claims Denial	179	27%
Utilization Review	237	35%
Education/Counseling	24	4%
Enrollment/Eligibility	26	4%
Poor Customer Service	40	6%
Other	80	12%
Total	673	101%*

\*adds up to more than 100 percent due to rounding  
 Source: OMCO database.



### Summary

There are four separate state entities that receive and respond to health care complaints. Each database is unique and maintained separately with different categories used to capture the nature and outcome of health care complaints submitted by providers and consumers. Obtaining a complete picture of the complaint activity occurring at the state level and identifying trends across agencies is difficult because of the lack of integration, as well as lack of communication among state agencies handling the complaints.

### 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 chapter, 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 D.

**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 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. If the respondent was not eligible for reimbursement he or she was instructed to not complete the rest of the survey. However, this would not prevent someone from 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 a range of 77 to about 356 providers actually responded to specific survey questions. Table V-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 <sup>1</sup>	2	--
None of the Above	48	8%
Total	632	100%

<sup>1</sup>The committee could not obtain 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 V-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 9 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 practices. 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 about 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 V-3 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 complaints 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 complaints were filed, the most common reason given was because of claim denials and delays followed by prior authorization denials.

Respondents who had filed complaints with any of the agencies, including those that may have filed the same complaint across agencies, were asked to rate the overall effectiveness of the agency in resolving the complaint. Of the 42 survey respondents who had filed a complaint with the Office of the Attorney General, 67 percent rated the office effective. There were 49

respondents who had filed a complaint with OHA and a majority of those respondents (52 percent) rated the office effective in resolving complaints. Finally, 47 respondents had filed a complaint with the insurance department and it received the lowest rating by providers with only 37 percent indicating it was effective.

<b>Table V-3. How Treatment Was Changed Because of Utilization Review Process. N=251</b>		
<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.		

### **Summary**

Acknowledging the survey limitations, most mental health providers responding to the program review survey 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.

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### 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 one part of CID's broader managed care regulatory responsibilities.

### Health Insurance Data Request and Response

Because of the lack of information collected by any state 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'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 E.

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 enrollees. None of the insurers were able to fully comply with the committee's request because:

- some of the statistics requested by committee 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 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 Chapter Three, 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 for the variation. 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:

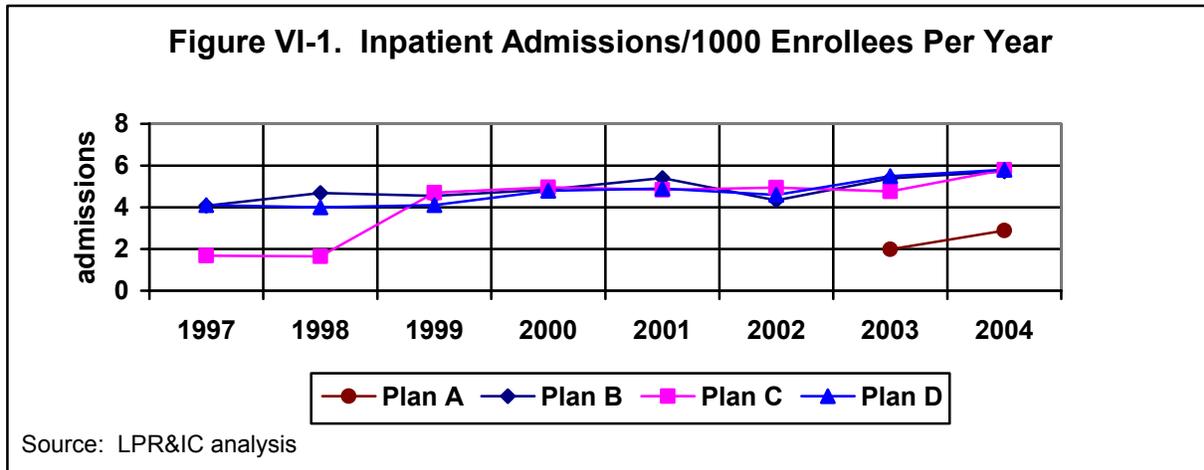
- all measures of utilization of mental health treatment increased regardless of the level of care (inpatient or outpatient);
- a standard measure used to compare year-to-year costs, known as per member per year costs, also shows increases for both inpatient and outpatient mental health treatment; and
- 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 of various mental health measures can be made, the analysis contained in this chapter highlights the data submitted from 1997 by three large health insurers that 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 Data

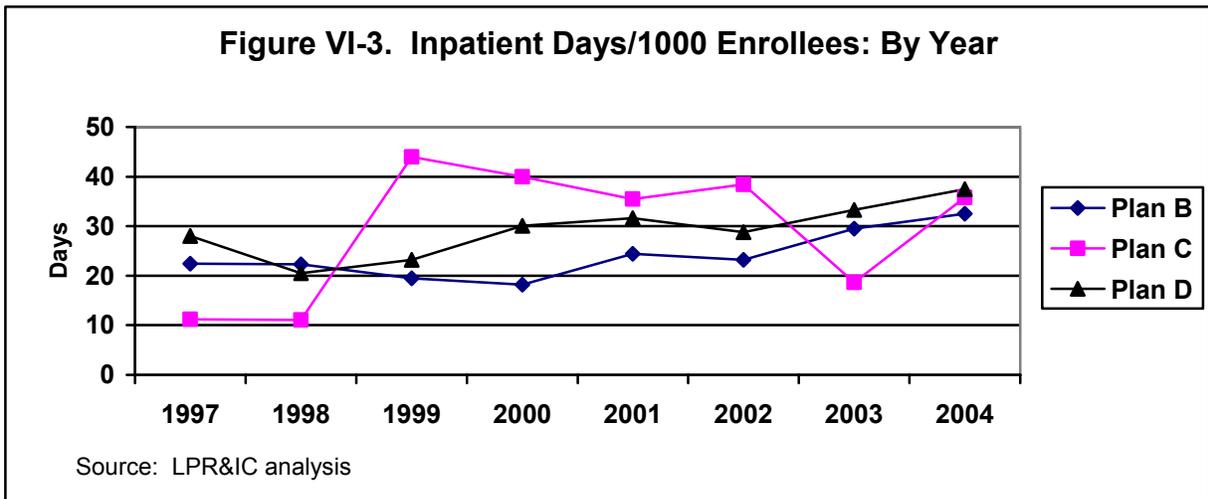
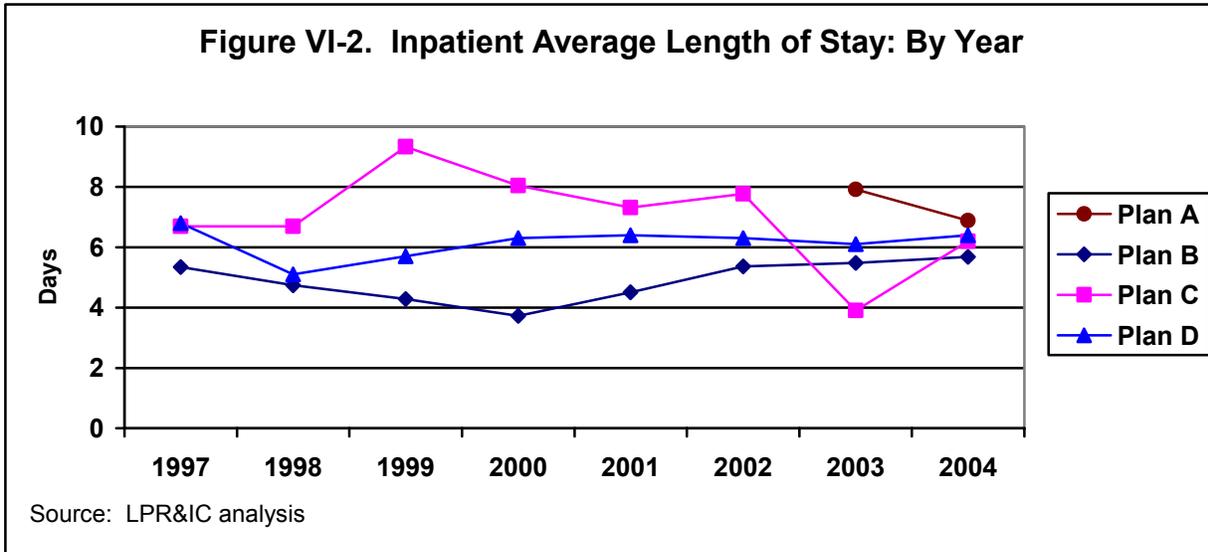
**Inpatient admissions.** Figure VI-1 shows the number of inpatient mental health admissions per 1000 enrollees, a standard measure of utilization. As shown in the figure, the number of inpatient admissions per 1000 enrollees has increased for all three plans with data since 1997, with the greatest overall 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.

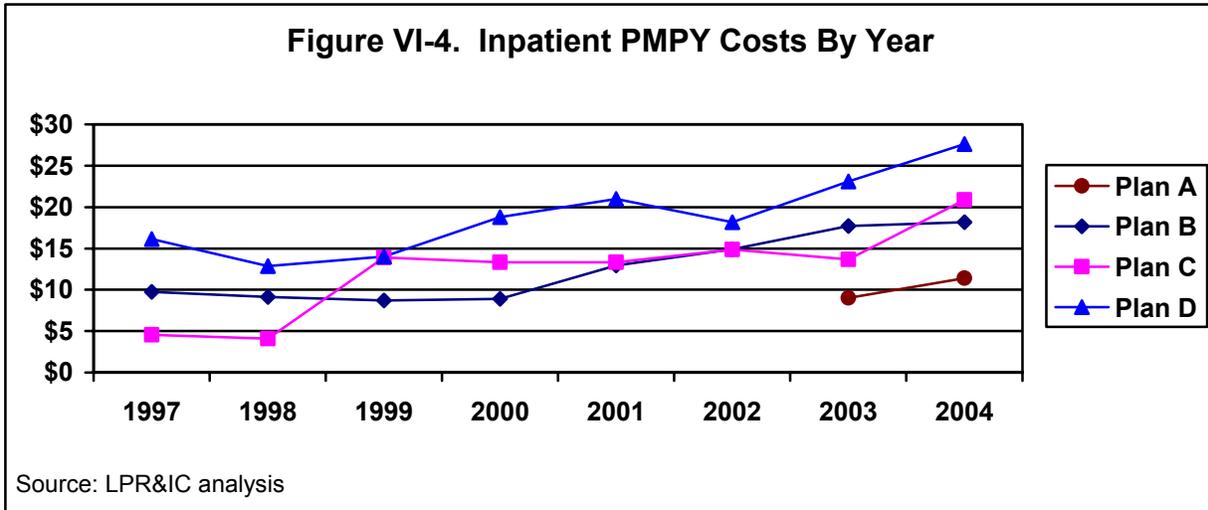
**Average length of stay.** A standard hospital measure used to determine the average amount of time between admission and discharge for patients is average length of stay (ALOS). Figure VI-2 shows the average length of stay for enrollees hospitalized for behavioral mental health reasons. Plan C had 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 VI-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 VI-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.



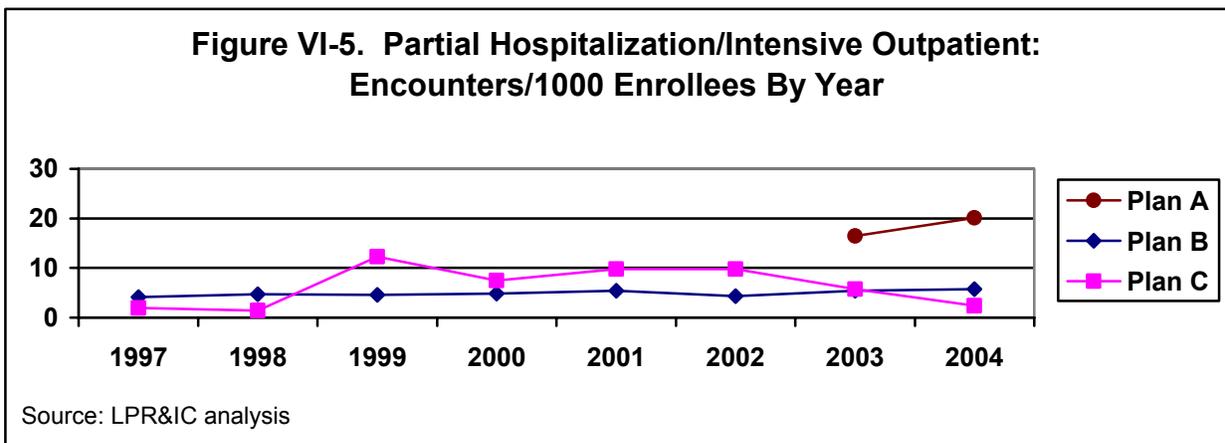
**Costs.** Figure VI-4 shows per member per year (PMPY) costs for inpatient mental health treatment for three insurers with complete cost data (two years of data from a fourth insurer is also shown). Trends for all three plans with data from 1997 show overall costs increased when two points in time are 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 year<sup>10</sup>, 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.

<sup>10</sup> <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 VI-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 VI-1).

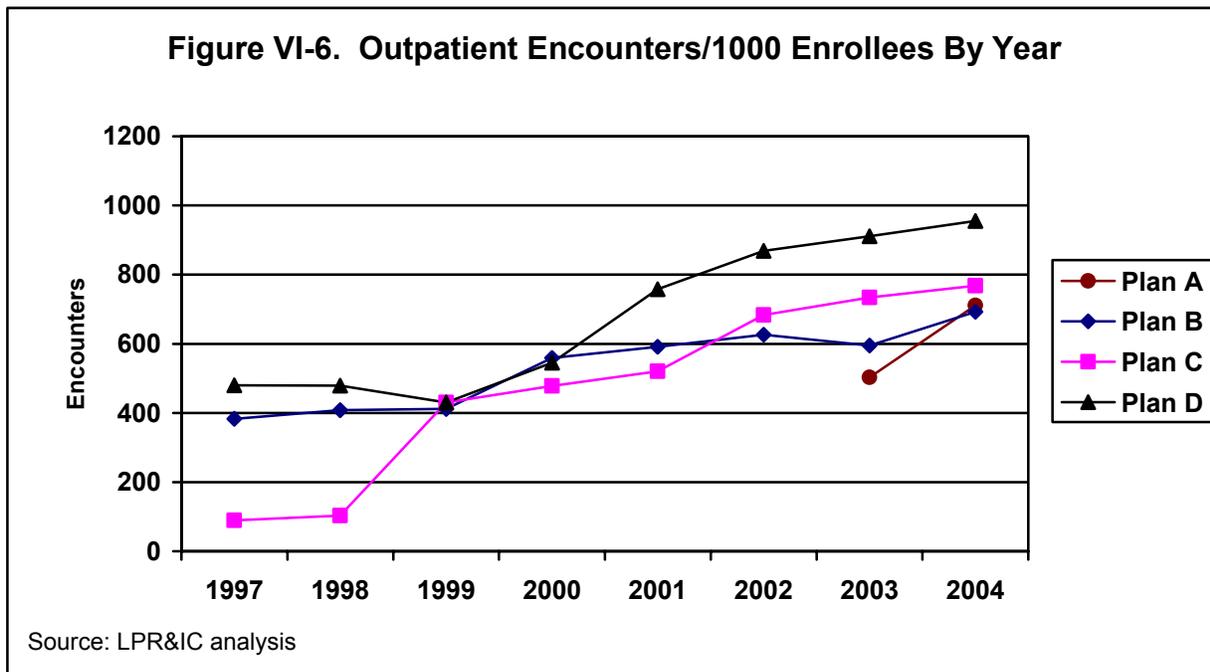


**Outpatient Mental Health Data**

**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 VI-6. An encounter

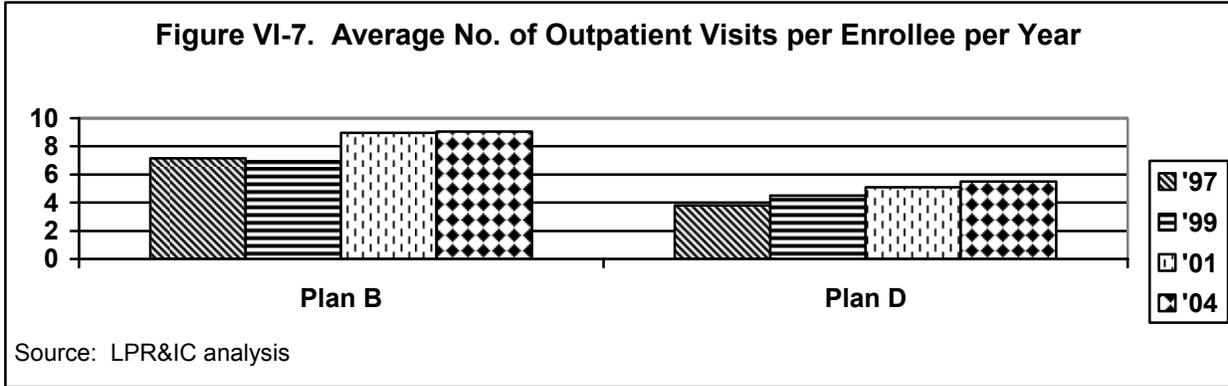
is defined as a face-to-face meeting between an insured person and a health care provider where services are provided or rendered.

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 an 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 VI-6.

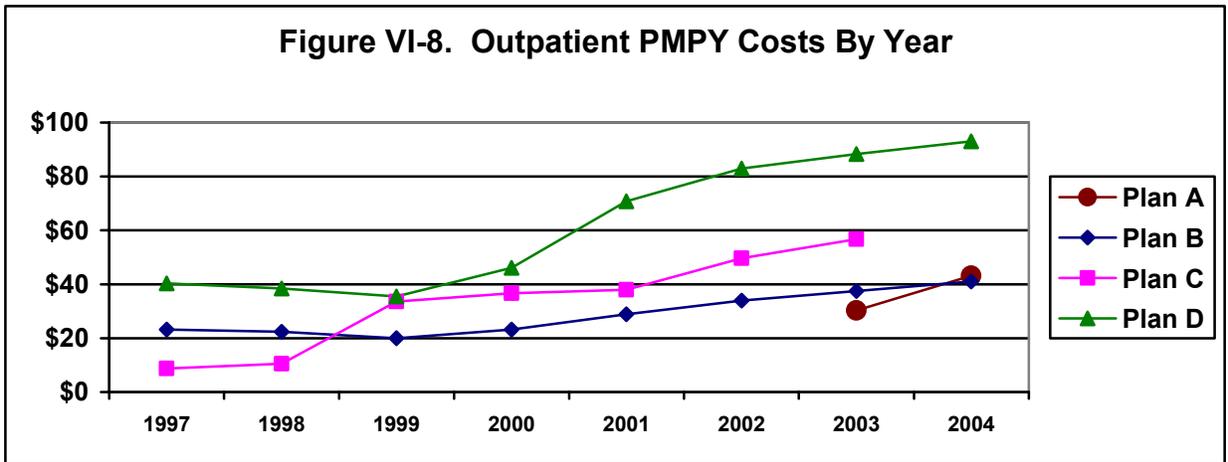


While the figure shows that there are increasing encounters per 1000 enrollees, it cannot show whether more enrollees are accessing mental health services or more services are being provided to the same number of enrollees. Further data would need to be obtained in order to perform analysis to determine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

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### 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 discussed earlier in this 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 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.<sup>11</sup>

The committee's recommendations in this chapter 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.

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<sup>11</sup> 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, publication 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 Chapter Three. 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 the responsibility of the health insurer to be aware of any new requirements and file a policy amendment with the division for approval and notify its enrollees of any coverage changes. 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. 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 be reported separately from all other determinations.

As presented in Chapter Three, 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 denials for general health services have increased.*

*Data limitations.* Chapter Three 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.”<sup>12</sup> *The committee found other 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.*

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

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<sup>12</sup> 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.

**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 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:

- 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 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. 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-478I 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 and anticipates hiring a Legislative and Administrative Advisor in April 2006. 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 in 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 category:**
  - **the reason for the request (i.e., inpatient admission, service, procedure, or 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.**

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 when 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.

As noted in Chapter Four, Public Act 05-289 established a Mental Health Parity Workgroup based on a recommendation in the Lieutenant Governor’s Mental Health Cabinet 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. **Therefore, the committee recommends:**

**The Mental Health Parity Workgroup established by Public Act 05-280 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

Chapters Three and Four describe 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 VII-1 shows the total number of complaints filed in 2004 and the numbers that were mental health related.

<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 <sup>1</sup>	108	29
Office of the Attorney General	1,038	91
Office of the Healthcare Advocate	959	135
<b>Total</b>	<b>7,209</b>	<b>1,111</b>

<sup>1</sup> C.G.S. Sec. 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 “external 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 are 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.*

Since CID is the agency that regulates insurance, it should be using this information to identify whether any patterns or practices exist at 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**

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## APPENDIX A

### STATE MENTAL HEALTH PARITY LAWS

State n=33	Eligible Population	Coverage Requirements	Cost Containment and Other Provisions
<b>Alabama (2002)</b>	<b>Mandated offering for</b> small groups and individuals	Services for treatment of <b>“biologically-based mental disorders”</b> only	
<b>Arkansas (1997)</b>	Groups > 50 employees	Services for treatment of <b>“mental illnesses and developmental disorders”</b> as defined in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders or DSM	<ul style="list-style-type: none"> <li>• Health plans must provide mental health benefits under same terms as for other medical illnesses</li> <li>• Health plans may use a carve-out arrangement, prior authorization and other managed care techniques</li> <li>• <b>Exemption</b> if health plan’s actuary determines costs would raise average premium rates by &gt; 1.5%</li> </ul>
<b>California (1999)</b>	All employer groups/ Individuals	Services for treatment of: <ul style="list-style-type: none"> <li>• <b>“severe mental illness”</b> (schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, autism, anorexia nervosa and bulimia)</li> <li>• <b>“serious emotional disturbances of a child”</b> (one or more mental disorders as defined in the DSM, except substance abuse or developmental disorders that result in inappropriate behavior)</li> </ul>	Health plans may use case management, networks, UR techniques, prior authorization, copayments or other cost-sharing arrangements
<b>Colorado (1997)</b>	All employer groups	Services for treatment of <b>“biologically-based mental disorders”</b> (schizophrenia, affective disorder, bipolar disorder, major depression, obsessive-compulsive disorder and panic disorder)	Health plans must provide coverage of biologically-based mental illness that is no less extensive than for other physical illness

State	Eligible Population	Coverage Requirements	Cost Containment and Other Provisions
<b>Connecticut</b> (1997, 1999)	All employer groups	<ul style="list-style-type: none"> <li>Services for treatment of “<b>mental and nervous conditions</b>” (mental disorders as defined in DSM, including <b>substance abuse</b>)</li> <li><b>excludes</b> mental retardation, learning disorders, motor skills disorders, communication disorders, caffeine-related disorder, relational problems)</li> </ul>	<b>Requires Full Parity:</b> No policy shall establish any terms or conditions that place greater financial burden on enrollees seeking diagnosis or treatment of mental or nervous conditions
<b>Delaware</b> (1998, 2001)	All employer groups/ Individuals	Services for treatment of “ <b>biologically-based mental disorders</b> ” (schizophrenia, schizoaffective disorder, bipolar disorder, obsessive-compulsive disorder, major depression, panic disorder, anorexia nervosa, bulimia nervosa and delusional disorder) and treatment for <b>drug and alcohol dependencies</b>	Health plans may provide services in a managed care setting and evaluate requests for coverage based on medical necessity principles
<b>Georgia</b> (1998)	<b>Mandated offering</b> for All employer groups/ Individuals	<ul style="list-style-type: none"> <li>Mental health coverage for individuals for no more than 30 days and 48 visits per year</li> <li>Mental health coverage for groups comparable to that of other physical illnesses covered under a health plan’s contract</li> </ul>	<ul style="list-style-type: none"> <li>Health plans may set day and visit limits on coverage for small groups (&lt; 50 employees)</li> <li>Health plans may carve out mental health services and deliver in managed care setting</li> <li>Requires DOI to study mandate’s effect on premiums</li> </ul>
<b>Hawaii</b> (1999)	All employer groups	Services for treatment of “ <b>serious mental illness</b> ” (schizophrenia, schizoaffective disorder and bipolar disorders)	<ul style="list-style-type: none"> <li>Proportion of deductibles/copayments may not be greater than those applied to comparable physical illness</li> <li>Allows health plans to set durational limits that are actuarially equivalent to mental health benefits required</li> </ul>

State	Eligible Population	Coverage Requirements	Cost Containment and Other Provisions
<p><b>Illinois</b> (2001)</p>	<p>Large groups (&gt;50 employees)</p>	<p>Services for treatment of “<b>serious mental illness</b>” (schizophrenia, paranoid and other psychotic disorders, bipolar disorders, major depressive disorders, schizoaffective disorders, pervasive developmental disorders, obsessive-compulsive disorders, childhood depressions, and panic disorder)</p>	<ul style="list-style-type: none"> <li>• Health plans must provide coverage for treatment of serious mental illnesses under the same terms and conditions as coverage related to other illnesses and diseases</li> <li>• Upon request of health plan, providers must furnish data that substantiate that treatment is medically necessary</li> <li>• Directs DOI to prepare cost-benefit impact study for legislature by March 2005; mandate will sunset end of 2005</li> </ul>
<p><b>Indiana</b> (1999)</p> <p>(2001)</p>	<p>Large groups (&gt; 50 employees/ Individuals</p> <ul style="list-style-type: none"> <li>• Mandated requirement for group products</li> <li>• <b>Mandated offering</b> for individuals</li> </ul>	<p>Services for treatment of “<b>mental illness</b>” as defined in a health plan’s contract</p> <p>Services for treatment of pervasive developmental disorders, including autism and Asperger’s syndrome</p>	<ul style="list-style-type: none"> <li>• Treatment limits or financial requirements on coverage for mental illness must be same as for medical/surgical conditions</li> <li>• <b>Exemption</b> if an employer’s premium increases by more than 4%</li> </ul> <p>Coverage may not be subject to dollar limits or cost-sharing provisions that are less favorable than those which apply to physical illnesses</p>
<p><b>Kansas</b> (2001)</p>	<p>All employer groups</p>	<p>Services for treatment of “<b>mental illness</b>” (schizophrenia, schizoaffective disorder, reactive and atypical psychosis, delusional disorder, major affective disorders, dysthymic disorders, obsessive-compulsive disorder, panic disorder, and pervasive developmental disorder including autism)</p>	<ul style="list-style-type: none"> <li>• Such coverage shall be subject to same deductibles, coinsurance and other limits as apply to other covered services, <b>except</b> a health policy is in compliance if it includes 45 inpatient days and 45 outpatient visits per year</li> </ul>

State	Eligible Population	Coverage Requirements	Cost Containment and Other Provisions
<b>Kentucky</b> (2000)	Groups > 50 employees	<ul style="list-style-type: none"> <li>Services for treatment of “<b>mental health conditions</b>” (any condition or disorder that involves mental illness or <b>alcohol and other drug abuse</b> that falls under any of the diagnostic categories listed in DSM)</li> <li><b>excludes</b> pervasive developmental disorders (except autism), behavioral disorders, learning disabilities, retardation and caffeine/nicotine addiction</li> </ul>	<ul style="list-style-type: none"> <li>Health plans must provide coverage of any treatment for a mental health condition under same terms as for a physical health condition</li> <li>Insurance Commissioner must submit an annual report on Act’s cost impact</li> </ul>
<b>Louisiana</b> (1999)	All employer groups	Services for treatment of “ <b>severe mental illness</b> ” (schizophrenia or schizoaffective disorder, bipolar disorder, autism, panic disorder, obsessive-compulsive disorder, major depressive disorder, anorexia, bulimia, Asperger’s disorder, intermittent explosive disorder, post-traumatic stress disorder, Rett’s disorder, and Tourette’s disorder)	Specifies that a health policy is in compliance if benefits include 45 inpatient days and 52 outpatient visits per year
<b>Maine</b> (1995, 2003)	<ul style="list-style-type: none"> <li>Mandated requirement for large groups (&gt; 20 employees)</li> <li><b>Mandated offering</b> for small groups and individuals</li> </ul>	Services for treatment of “ <b>mental health conditions</b> ” (psychotic, dissociative, mood, anxiety, personality and tic disorders; paraphilias; attention deficit and pervasive developmental disorders; bulimia, anorexia; and substance abuse-related disorders)	Proportion of deductibles/copayments for mental health services may not be greater than those applied to comparable physical illness
<b>Massachusetts</b> (2000)	All employer groups/ Individuals	<ul style="list-style-type: none"> <li>Services for treatment of “<b>biologically-based illnesses</b>” (schizophrenia, bipolar disorder, or any other condition so defined in the DSM)</li> <li>Services for rape-related mental or emotional disorders, once costs exceed \$25,000</li> </ul>	Health plans must treat mental illnesses in the same manner as physical illnesses

State	Eligible Population	Coverage Requirements	Cost Containment and Other Provisions
<b>Maryland</b> (1994)	All employer groups/ Individuals	Services for treatment of <b>mental illnesses, emotional disorders, drug abuse and alcohol abuse</b> which in professional judgment of practitioners is medically necessary and treatable	<ul style="list-style-type: none"> <li>• Coverage for inpatient mental health benefits must be on same terms as for physical illness</li> <li>• Cost-sharing for outpatient visits rises with utilization: 80% for first 5 visits; 65% for 6<sup>th</sup>-30<sup>th</sup> visit; and 50% thereafter</li> <li>• Authorized benefits to be subject to a managed care system</li> </ul>
<b>Minnesota</b> (1994)	All employer groups/ Individuals	Services for treatment of “ <b>mental health and chemical dependency</b> ” as defined in a health plan’s contract	<b>Requires Full Parity:</b> Cost-sharing requirements and benefit limitations for inpatient and outpatient mental health and chemical dependency services must not place a greater financial burden on enrollees or be more restrictive than for medical services
<b>Missouri</b> (1997, 1999, 2004)	All employer groups  <b>Mandated offering</b> only for individuals	<ul style="list-style-type: none"> <li>• Services for treatment of “<b>mental illness</b>” defined as disorders recognized in the DSM (except mental retardation)</li> <li>• Also provides for a second, catastrophic coverage option limited primarily to biologically-based disorders</li> </ul>	<ul style="list-style-type: none"> <li>• Health plans may set durational limits for treatment of substance abuse</li> <li>• Health plans may deliver services on a managed care basis and determine medically necessary and clinically appropriate care</li> <li>• <b>Exemption</b> if compliance increases premium by &gt; 2% over two years</li> </ul>
<b>Montana</b> (1999)	All employer groups/ Individuals	Services for treatment of “ <b>severe mental illness</b> ” (schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder and autism)	<ul style="list-style-type: none"> <li>• Health plans must provide benefits for severe mental illness that are no less favorable than for other physical illnesses</li> <li>• Benefits may be subject to managed care provisions contained in a contract</li> </ul>

State	Eligible Population	Coverage Requirements	Cost Containment and Other Provisions
<p><b>Nebraska</b> (1999)</p>	<p>Large groups (&gt; 15 employees)</p>	<p>Services for treatment of “<b>serious mental illness</b>” (schizophrenia, schizoaffective disorder, delusional disorder, bipolar disorder, major depression and obsessive compulsive disorder)</p>	<ul style="list-style-type: none"> <li>• Health plans may not place a greater financial burden on an enrollee for serious mental illness than for treatment of a physical health condition</li> <li>• Health plans may use managed care techniques to determine and arrange for medically necessary and clinically appropriate mental health care</li> </ul>
<p><b>New Hampshire</b> (1994, 2002)</p>	<p>All employer groups</p>	<p>Services for treatment of “<b>biologically-based mental illnesses</b>” (schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, autism, anorexia nervosa, bulimia nervosa, and post-traumatic stress disorder)</p>	<p>Coverage for biologically-based mental illness must be provided under same terms and be no less extensive than care for physical illness</p>
<p><b>New Jersey</b> (1999)</p>	<p>All employer groups/ Individuals</p>	<p>Services for treatment of “<b>biologically-based mental illness</b>” (schizophrenia, Schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and autism)</p>	<p>Terms of coverage for biologically-base mental illness must be same as for medical/surgical care with respect to cost-sharing and benefit limits</p>
<p><b>New Mexico</b> (2000)</p>	<p>All employer groups</p>	<p>“<b>Mental health benefits</b>” means benefits as described in the health plan’s contract</p>	<ul style="list-style-type: none"> <li>• Health plans may not impose limits or financial requirements on mental health benefits if identical terms are not imposed for other conditions</li> <li>• <b>Exceptions allowed</b> for small groups (2-49 employees) if premiums rise &gt; 1.5% and for large groups if premiums rise &gt; 2.5% (i.e., higher employee cost-sharing or reduced coverage)</li> </ul>

State	Eligible Population	Coverage Requirements	Cost Containment and Other Provisions
<b>Oklahoma</b> (1999)	Large groups (> 50 employees)	Services for treatment of “ <b>severe mental illness</b> ” (schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder and obsessive-compulsive disorder)	<ul style="list-style-type: none"> <li>• Coverage of severe mental illness must be subject to same prior authorization and UR</li> <li>• <b>Exemption</b> if group’s premium rises 2% after first year</li> <li>• Requires DOI to analyze cost impact and report by December 2002; mandate will sunset if cumulative premiums rise &gt; 6% after three years</li> </ul>
<b>Oregon</b> (1987)	All employer groups	Services for treatment of mental or nervous conditions and <b>chemical dependency</b> (except tobacco-related addictions)	<ul style="list-style-type: none"> <li>• Requires parity <b>only for cost-sharing</b></li> <li>• Specifies that a health plan is in compliance if annual benefit payments are no less than \$10,500 for adults and \$12,500 for children</li> </ul>
<b>Rhode Island</b> (1994, 2001)	All employer groups/ Individuals	<ul style="list-style-type: none"> <li>• Services for treatment of “<b>any mental disorder and substance abuse disorder</b>” as defined in the DSM</li> <li>• <b>excludes</b> mental retardation, learning disorders, motor skills disorders, communication disorders, and tobacco/caffeine-related addictions</li> </ul>	<ul style="list-style-type: none"> <li>• Limits coverage for outpatient services to 30 visits in a calendar year</li> <li>• If a provider cannot establish medical necessity, neither health plan nor patient shall be obligated to reimburse</li> <li>• Mandate only applies to mental health services delivered by in-state facilities</li> </ul>
<b>South Dakota</b> (1998)	All employer groups	Services for treatment of “ <b>biologically-based mental illnesses</b> ” (schizophrenia and other psychotic disorders, bipolar disorder, major depression and obsessive-compulsive disorder)	Coverage for biologically-based mental illnesses must have same dollar limits, deductibles, coinsurance factors and restrictions as for other covered illnesses
<b>Tennessee</b> (1998)	Large groups (> 25 employees)	Mental health coverage shall provide a minimum of 20 inpatient days and 25 outpatient visits	<ul style="list-style-type: none"> <li>• Health plans must apply same deductibles and co-payments to mental health services as for physical illnesses</li> <li>• <b>Exemption</b> if premiums rise by 1%</li> </ul>

State	Eligible Population	Coverage Requirements	Cost Containment and Other Provisions
<p><b>Texas</b> (1997)</p>	<p>Mandated requirement for large groups (&gt; 50 employees)</p> <p><b>Mandated offering</b> for small groups (2-50 employees)</p>	<p>Services for treatment of “<b>serious mental illness</b>” (schizophrenia, schizoaffective disorders, paranoid and other psychotic disorders, bipolar disorder and major depression)</p>	<ul style="list-style-type: none"> <li>• Health plans must provide mental health coverage of 45 inpatient days and 60 outpatient visits annually based on medical necessity</li> <li>• Health plans must impose same amount limits and cost-sharing for serious mental illness as for physical illness</li> </ul>
<p><b>Utah</b> (2000)</p>	<p><b>Mandated offering</b> for All employer groups</p>	<ul style="list-style-type: none"> <li>• Services for treatment of “<b>mental illness</b>” as defined in the DSM</li> <li>• <b>excludes</b> relational problems, social maladjustment, conduct disorder, personality disorder, learning disability and mental retardation</li> </ul>	<ul style="list-style-type: none"> <li>• Health plans must offer catastrophic mental health coverage on a parity basis</li> <li>• Different cost-sharing can be applied to mental and physical illnesses, but once out-of-pocket limit is reached, coverage is provided for mental illnesses at same level as for physical illnesses</li> </ul>
<p><b>Vermont</b> (1997)</p>	<p>All employer groups/ Individuals</p>	<p>Services for treatment of “<b>mental illness and substance abuse</b>” as listed in the ICD</p>	<ul style="list-style-type: none"> <li>• <b>Requires Full Parity:</b> Coverage for mental illness and substance abuse treatment must be equal to physical health in payment limits, cost-sharing and day/visit limits</li> <li>• Health plans may require enrollees to receive benefits through managed care</li> </ul>
<p><b>Virginia</b> (1999)</p>	<p>Large groups (&gt; 25 employees)</p>	<p>Services for treatment of “<b>biologically-based mental illness and drug and alcohol addiction</b>” (schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, attention deficit disorder and autism)</p>	<ul style="list-style-type: none"> <li>• Mental health and substance abuse coverage must be same as coverage for other illnesses in terms of cost-sharing, durational limits and payment limits</li> <li>• Health plans may apply same medical necessity criteria to mental health benefits as used for other illnesses</li> </ul>
<p><b>West Virginia</b> (2002)</p>	<p>All employer groups</p>	<p>Services for treatment of “<b>serious mental illness</b>” (schizophrenia/other psychotic disorders, bipolar disorders, depressive disorders, <b>substance-related disorders</b> (except caffeine/nicotine), anxiety disorders, and anorexia/bulimia)</p>	<ul style="list-style-type: none"> <li>• <b>Exemption</b> if large employer’s mental health costs increase to 2% of total costs or by 1% for small employers</li> <li>• Remedy would impose unspecified costs controls on mental health benefit</li> </ul>

Source: Blue Cross Blue Shield Association, December 2004

## APPENDIX B

<b>Comparison of Employee Copays for Mental Health Services and Employee Share of Premiums by Plan Type.</b>			
<i>Benefit</i>	<i>POE and POI-G</i>	<i>POS In Network</i>	<i>POS Out-of-Network</i>
<b><i>Prior Authorization Required</i></b>			
Mental Health			
• Inpatient		100%	80%
• Outpatient	\$5 copay	\$10 copay	80%
Substance Abuse			
• Detoxification		100%	80%
• Inpatient		100%	80%
• Outpatient	\$5 copay	\$10 copay	80%
<b>Employee Share of Premium</b>			
<i>Type of Plan</i>	<i>Subscriber</i>	<i>Subscriber+1</i>	<i>Family</i>
<b>Point of Service</b>			
Anthem State Preferred POS	\$40.58	\$137.52	\$163.32
Anthem State Blue Care POS	\$12.22	\$68.86	\$81.26
Health Net Charter POS	\$12.45	\$70.16	\$82.80
Oxford Freedom Select POS	\$11.93	\$67.24	\$79.35
<b>Point of Enrollment (POE)</b>			
Anthem State BlueCare POE	\$5.73	\$42.54	\$60.26
Health Net Charter POE	\$5.73	\$42.54	\$60.25
Oxford HMO Select POE	\$5.35	\$41.15	\$58.28
<b>Point of Enrollment - Gatekeeper</b>			
Anthem State BlueCare POE Plus	\$3.42	\$34.88	\$47.98
Health Net Passport HMO	\$3.42	\$35.83	\$49.28
Oxford HMO	\$3.04	\$31.54	\$43.37
Source: Office of the Comptroller.			

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## Appendix C

### Health Insurance Mandates for Group Health Plans

- UR company licensed
- 38a-478g(b) Plan description Managed care plans

#### **Required mandates**

- 38a-514 Mental illness parity
- 38a-515 – Mentally or physically handicapped dependents
- 38a-516 Newborn children
- 38a-516a Early intervention (Birth to 3)
- 38a-516b Hearing aids for children 12 and younger
- 38a-516c Craniofacial disorders
- 38a-517a In-hospital dental services
- 38a-518 Accidental ingestion of a controlled drug
- 38a-518a Hypodermic needles and syringes
- 38a-518c Protein modified foods/formula for children up to 3
- 38a-518d Diabetes coverage
- 38a-518e Diabetes self-management training
- 38a-518g Prostate screening
- 38a-518h Lyme disease treatment
- 38a-518i Pain Management
- 38a-518j Ostomy appliances and supplies
- 38a-518k Colorectal cancer screening
- 38a-520 Home health care
- 38a-524 Occupational therapy
- 38a-525 Emergency ambulance services
- 38a-529 Veterans home and hospital coverage
- 38a-530 – Mammography
- 38a-530c Maternity and postpartum care
- 38a-530d Mastectomy
- 38a-535 Preventive pediatric care
- 38a-537 15 day notice of cancellation
- 38a-541 Spousal coverage
- 38a-542 Tumors and leukemia (incl. removal of breast implants)
- 38a-542a–g Cancer clinical trials
- 38a-543 Age discrimination prohibited
- 38a-546 Continuation of coverage
- 38a-554 Continuation of coverage and conversion
- 38a-549 Adopted children

**Rev 2/18/05**

**Check for (can't be contrary)**

- 38a-530e Contraceptives
- 38a-518b Cancer drugs not to be excluded
- “actively at work” language”
- 38a-476 and HIPAA – pre-existing conditions
- 38a-513b Def. of “experimental or investigational
- PA01-171 sec 17 Psychotropic drug availability
- 38a-530b Pap smear tests

**Optional**

- 38a-536 Infertility (not applicable to HMOs)

**Health Insurance Mandates for Individual Policies**

- UR company licensed
- 38a-478g(b) Plan description

**Required mandates**

- 38a-488a Mental illness parity
- 38a-489 Mentally or physically handicapped dependents
- 38a-490 Newborn children
- 38a-490a Early intervention (Birth to 3)
- 38a-490b Hearing aids for children 12 and younger
- 38a-490c Craniofacial disorders
- 38a-491a In-hospital dental services
- 38a-492 Accidental ingestion of a controlled drug
- 38a-492a Hypodermic needles and syringes
- 38a-492c Protein modified foods/formula for children up to 3
- 38a-492d Diabetes coverage
- 38a-492e Diabetes self-management training
- 38a-492g Prostate screening
- 38a-492h Lyme disease treatment
- 38a-492i Pain Management
- 38a-492j Ostomy appliances and supplies
- 38a-492k Colorectal cancer screening
- 38a-493 Home health care
- 38a-496 Occupational therapy
- 38a-498 Emergency ambulance services
- 38a-503 – Mammography
- 38a-503c Maternity and postpartum care
- 38a-503d Mastectomy
- 38a-504 Tumors and leukemia (incl.rem. of breast implants)

- 38a-504a-504g Cancer clinical trials
- 38a-508 Adopted children

**Check for (can't be contrary)**

- 38a-492b Cancer drugs not to be excluded
- 38a-503e Contraceptives
- "actively at work" language
- 38a-476 and HIPAA – pre-existing conditions
- 38a-483c Def. of "experimental or investigational"
- PA01-171 sec 17 Psychotropic drug availability
- 38a-503b Pap smear tests

**Rev 2/18/05**

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**APPENDIX D**  
**COMMITTEE SURVEY OF MENTAL HEALTH CARE PROVIDERS**

1. Please identify your profession (i.e., type of license issued to you by the Department of Public Health):			
		<b>Response Percent</b>	<b>Response Total</b>
medical doctor (psychiatrist)	██████	12.8%	81
clinical psychologist	██████	12.8%	81
advanced practice registered nurse	█	4.9%	31
<b>clinical social worker</b>	██████████████████	<b>41.6%</b>	<b>263</b>
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
<b>Total Respondents</b>			<b>632</b>
(skipped this question)			0

2. Please rate the effectiveness of the 1999 mental health parity law on:				
	<b>Very Effective</b>	<b>Somewhat Effective</b>	<b>Not Effective</b>	<b>Response Average</b>
Expanding access to mental health treatment	15% (54)	<b>56% (198)</b>	28% (99)	<b>2.13</b>
Expanding access to mental health providers	14% (47)	<b>45% (154)</b>	42% (145)	<b>2.28</b>
Improving the quality of mental health treatment	12% (40)	38% (131)	<b>51% (176)</b>	<b>2.39</b>
Reducing stigma associated with mental illness	11% (37)	44% (152)	<b>46% (159)</b>	<b>2.35</b>
<b>Total Respondents</b>				<b>350</b>
(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)	<b>41% (143)</b>	25% (87)	26% (91)	2.68
processing claims to providers	11% (37)	<b>42% (147)</b>	16% (57)	31% (108)	2.68
expanding provider networks	17% (59)	33% (115)	15% (53)	<b>35% (122)</b>	2.68
<b>Total Respondents</b>					<b>351</b>
(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
<b>20 years or more</b>	<b>45.5%</b>	<b>162</b>
<b>Total Respondents</b>		<b>356</b>
(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
<b>20 - 30 patients</b>	<b>28.2%</b>	<b>99</b>
30 - 40 patients	13.4%	47
more than 40 patients	12.5%	44
<b>Total Respondents</b>		<b>351</b>
(skipped this question)		283

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

	Response Percent	Response Total
<b>private practice in the community</b>	<b>70.1%</b>	<b>249</b>
clinic based	16.1%	57
hospital based	18.6%	66
Other (please specify)	18.9%	67
<b>Total Respondents</b>		<b>355</b>
(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
<b>Total Respondents</b>			<b>327</b>
<b>(skipped this question)</b>			<b>305</b>

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
<b>Total Respondents</b>			<b>341</b>
<b>(skipped this question)</b>			<b>293</b>

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
<b>Total Respondents</b>			<b>343</b>
<b>(skipped this question)</b>			<b>291</b>

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
<b>inadequate reimbursement</b>		<b>67.9%</b>	<b>114</b>
contract difficulties		25%	42
difficult obtaining prior authorization		40.5%	68
poor customer service		42.3%	71
Other (please specify)		35.7%	60
<b>Total Respondents</b>			<b>168</b>

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
(skipped this question)			288

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
<b>3-7 days</b>		<b>38.8%</b>	<b>131</b>
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
<b>Total Respondents</b>			<b>338</b>
(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)	<b>50% (166)</b>	37% (122)	10% (34)	<b>2.55</b>
<b>Total Respondents</b>					<b>329</b>
(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
<b>prior authorization</b>		<b>98.4%</b>	<b>247</b>
<b>Total Respondents</b>			<b>251</b>
(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)	<b>41% (129)</b>	<b>2.92</b>
inpatient continued stay	2% (5)	13% (39)	32% (101)	<b>53% (166)</b>	<b>3.38</b>
partial hospitalization	6% (20)	31% (96)	21% (65)	<b>41% (128)</b>	<b>2.97</b>
intensive outpatient treatment	11% (33)	<b>34% (106)</b>	26% (80)	30% (94)	<b>2.75</b>
initial outpatient visits	<b>62% (205)</b>	22% (72)	5% (17)	10% (34)	<b>1.63</b>
additional outpatient visits	24% (79)	<b>48% (156)</b>	18% (59)	10% (34)	<b>2.15</b>
<b>Total Respondents</b>					<b>328</b>
(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
<b>Occasionally</b>	██████████████████	<b>37%</b>	<b>123</b>
Rarely	██████████	24.4%	81
Never	██████████	22.3%	74
<b>Total Respondents</b>			<b>332</b>
<b>(skipped this question)</b>			<b>302</b>

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
<b>frequency of visits lessened</b>	██	<b>84.6%</b>	<b>214</b>
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
<b>Total Respondents</b>			<b>253</b>
<b>(skipped this question)</b>			<b>379</b>

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
<b>not applicable (don't treat substance abuse patients)</b>	██	<b>45.4%</b>	<b>147</b>
<b>Total Respondents</b>			<b>324</b>
<b>(skipped this question)</b>			<b>310</b>

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
<b>Total Respondents</b>			<b>333</b>
(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
<b>Total Respondents</b>						<b>81</b>
(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
<b>Total Respondents</b>					<b>97</b>
(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
<b>depends on insurer</b>		<b>58.2%</b>	<b>173</b>
<b>Total Respondents</b>			<b>297</b>
<b>(skipped this question)</b>			<b>337</b>

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:

<b>Total Respondents</b>	<b>227</b>
<b>(skipped this question)</b>	<b>405</b>

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
<b>\$90 - \$100</b>		<b>18.8%</b>	<b>57</b>
\$101 - \$125		18.4%	56
\$126 - \$149		9.5%	29
\$150 - \$174		12.5%	38
more than \$175		7.9%	24
<b>Total Respondents</b>			<b>304</b>
<b>(skipped this question)</b>			<b>330</b>

34. Please specify the range in the reimbursement rate you receive from health insurers for a 45 - 50 minute therapy session?

<b>Total Respondents</b>	<b>251</b>
<b>(skipped this question)</b>	<b>381</b>

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
<b>\$11 - \$20</b>	■	<b>51.4%</b>	<b>145</b>
\$21 - \$30	■	19.1%	54
\$31 - \$40	■	3.9%	11
\$41 - \$50	■	3.5%	10
Other (please specify)	■	9.6%	27
<b>Total Respondents</b>			<b>282</b>
<b>(skipped this question)</b>			<b>352</b>

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

<b>Total Respondents</b>	<b>169</b>
<b>(skipped this question)</b>	<b>463</b>

## APPENDIX E

### 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

## APPENDIX F

### *AGENCY RESPONSES:*

Connecticut Insurance Department

Office of the Attorney General



# STATE OF CONNECTICUT

## INSURANCE DEPARTMENT

DATE: February 14, 2006  
TO: Carrie Vibert  
FROM: Susan Cogswell *Susan Cogswell*  
RE: Legislative Program Review and Investigations Committee's Report on Mental Health Parity

Thank you for your staff's work on this important issue.

The Insurance Department has asked the companies to voluntarily report the additional statistics recommended in the report. We do not believe that the information is readily available but we seek to find what barriers exist in reporting the information in the format requested.

On the matter of the Consumer Report Card, the Insurance Department has the statutory authority to compel submission of the data. We believe that the development and publication of the Report Card should stay with the Department as the template is well developed and can be improved as needed rather than starting from scratch. We will work in coordination with the Health Care Advocate to develop suggested changes.

We welcome the recommendation to consolidate complaint information from the Attorney General's Office and the Office of the Health Care Advocate with information obtained by the Insurance Department's Consumer Affairs Division. Trends are our most useful tools in assessing whether insurance companies are meeting their obligations.

RICHARD BLUMENTHAL  
ATTORNEY GENERAL



55 Elm Street  
P.O. Box 120  
Hartford, CT 06141-0120

Office of The Attorney General  
**State of Connecticut**

February 10, 2006

The Honorable Catherine Cook  
The Honorable Brendan Sharkey  
Co-chairs, Program Review and Investigations Committee  
State Capitol  
Hartford, Connecticut 06106

Dear *Cathy* *Brendan* Cook and Representative Sharkey:

I am writing to express my appreciation to the Program Review and Investigations Committee and its staff for its hard work and thoughtful recommendations concerning mental health parity.

As you are aware, my office receives numerous requests for assistance from individuals who are denied critical insurance benefits for important mental health care. Although the mental health parity law requires insurers to provide in their contracts insurance coverage for behavioral health services that are at least equal to coverage for physical health services, the uneven application of "medically necessary" determinations have resulted in less parity and more unfairness for those in need of mental health services.

I fully concur with the recommendation that the Insurance Department include in its annual report on health insurers complaint data from my office and the Healthcare Advocate. I will continue to work with the Healthcare Advocate and will coordinate our responses to the Insurance Department so that the annual report more accurately reflects the experience of patients in their efforts to obtain critical insurance coverage.

Thank you for providing me with the opportunity to formally submit comments on this report.

Very truly yours,

*Richard Blumenthal*  
Richard Blumenthal

RB/RFK/sk