



STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Testimony of the Connecticut Insurance Department

Before
The Program Review and Investigations Committee
June 29, 2012

Study of Access to Substance Abuse Treatment for Privately Insured Youth

Senator Fonfara and Representative Rowe, and Members of the Committee, the Insurance Department appreciates the opportunity to appear today and provide testimony on this important issue. I am Anne Melissa Dowling, Connecticut's Deputy Insurance Commissioner.

I would like to begin by outlining for the Committee the Insurance Department's role and responsibilities regarding substance abuse coverage for members of fully insured health benefit plans issued in the state. After that, my staff and I would be happy to answer any questions you might have.

The Insurance Department reviews and approves all health policies issued by indemnity insurance companies and HMOs prior to their being issued in Connecticut. Our Life and Health Division reviews these contracts to ensure compliance with all state and federal mandates, including mental health parity. In Connecticut, our statutes for mental health parity require that all policies provide coverage for mental and nervous conditions; including substance abuse and that the policies do not include any terms, conditions, or benefits that provide a greater financial burden on an insured for mental health benefits than for other medical conditions. Examples of a "greater financial burden" that would not be allowed are differences in the number of inpatient days or a higher deductible for mental health services.

The Connecticut mental health parity laws apply to individual and group policies (covering large and small employers) issued in Connecticut. The federal mental health parity law only applies to employers of 51 or more employees with an insured or self-insured plan.

The Department also issues licenses to utilization review (UR) companies conducting UR for fully insured plans issued in Connecticut. Utilization

review is a process used by health insurers, or their designated UR subcontractor, to review the medical appropriateness of a service given, or proposed to be given, to an enrollee in the health plan. Our statutes require specific minimum guidelines these companies must adhere to in order to obtain and maintain a license, including timelines for making decisions for services, internal appeals processes which must also include an expedited appeal process for situations that require immediate review and notification requirements. All denials must be in writing and include the specific reason for the denial, as well as the clinical rule or protocol used in reaching the decision which must be made available, free of charge, upon request. All denial letters must also include information regarding our external review process, which I will discuss later, as well as information regarding the Insurance Department and the Office of the Healthcare Advocate that the member may contact for assistance.

Although the Department reviews policy forms and licenses utilization review companies, as indicated above, health insurers may develop their own internal medical protocols for use in evaluating requests for medical services. There are options available to consumers who disagree with the medical decision of their health plan.

All health plans are required to have an internal appeals process for enrollees or their provider to challenge any denial of medical services. For situations warranting an urgent appeal, the consumer may have their doctor request an expedited appeal, which by law must be conducted within 72 hours. The appeal process is explained in detail in the member's health policy and also in any denial letter sent to the member.

After the consumer exhausts all avenues within the health plan, and the plan continues to deny their request for services, a request for an Independent External Review may be filed with the Insurance Department.

The External Review process is a program instituted in 1997 by the Connecticut legislature to provide a vehicle for consumers to have adverse medical decisions made by their health carrier reviewed by an independent party. This program was standardized in 2011 Connecticut legislation to conform to requirements of the federal Affordable Care Act legislation. All fully insured individual and group plans issued in the State of Connecticut are required under Connecticut law to participate in this program, which is administered in the Consumer Affairs Division of the Insurance Department.

The Department contracts with Independent Review Organizations (IRO) based on the statutory criteria set forth in statute. The entities selected must be independent and cannot in any way be affiliated with a health insurer or HMO.

The IRO reviews the entire medical file, the medical guidelines used by the health plan or utilization review company and any other relevant information submitted by the member and their provider to determine whether the health plan's denial should be upheld, reversed or modified. Decisions for standard external reviews are typically completed within 20 to 45 days, but enrollees have the option to have their doctor request that the decision be provided on an expedited basis for urgent situations. By law, the IRO must conduct their expedited review within 72 hours of the IRO's receipt of the external review file. Once the IRO has made their decision, all parties to the external review are notified of the outcome. The decision of the IRO is binding and final unless one of the parties chooses to file a lawsuit challenging the decision.

The Department's Consumer Affairs unit responds to consumer complaints on a wide variety of issues, including substance abuse and mental health issues. In addition, the Department fields consumer questions on insurance related topics. Complaints filed are forwarded to the insurance company for a response to the allegations in the consumer complaint. The insurer's response to the complaint is evaluated against applicable insurance law, policy language, and the consumer issues raised in the complaint. The Department takes necessary action to facilitate a resolution to the situation or to explain the actions taken by the carrier. If a complaint arises regarding the insurer's application of a medical protocol, the Department has, on occasion utilized the consulting services of the UConn Medical Center to retrospectively review these guidelines where an issue of deviation from "standards of care" have been noted.

Complaints and inquiries on substance abuse and mental health issues predominantly center on requests for services to treat these conditions. In some instances the insurer may deny services entirely, but more often the insurer may approve a lesser level of service than is requested by the consumer. For example, a parent may request that a child with a substance abuse or mental health issue be treated at an in-patient Residential Treatment Center, while the health plan may feel that the child can be effectively treated through Intensive Out-patient Therapy. Issues of appropriate level

of care are resolved through the carrier's internal appeal process as well as the state run External Review program, as mentioned previously.

The Department has compiled data to assist the Program Review and Investigations Committee staff in their efforts to gather information on this important topic. Data captured in the Department's complaint tracking system, as well as data from the External Review program has been forwarded to the committee. We are hopeful that the Committee can use this data as part of their overall study.

We appreciate the opportunity to appear today and are committed to working further with Committee staff on this issue.