

and substance use denials of coverage remain OHA's number one area of clinical cases and the number keeps increasing. In 2008, OHA handled 185 behavioral health cases. However, we have seen a nearly threefold increase in the frequency of these cases, with 524 behavioral health cases in 2012. Clearly, this issue is not going away.

Accordingly, in October 2012, OHA held a public forum focusing on barriers to access and delivery of mental health and substance use treatment and services. Our findings¹ indicated a need for an overall vision of an integrated behavioral health system, with an emphasis on early intervention and prevention as well as a comprehensive and innovative approach to delivery of these necessary services. Mental illness in the United States has significant and wide ranging impacts. Estimates place the direct and indirect costs from \$34 billion² to \$57 billion³ annually. Not only are the social and economic effects of mental illness vastly misunderstood, but individuals suffering with severe mental illness die an average of 25 years sooner than those without mental disease.⁴

Your action to begin to remedy these inequities in our mental health system is to be commended. The recommendation that prospective or concurrent utilization review requests involving treatment for a substance use or co-occurring disorder be treated as urgent care requests acknowledges the clinical reality that, in these cases, delays in the onset of treatment may be the difference between recovery or relapse. Individuals with substance use and addiction struggle on a daily basis, often complicated by an underlying co-morbid mental disorder. Delays in access to appropriate levels of care can not only hamper a person's treatment, it could result in a rapid deterioration of any progress made, requiring a repeated or lengthened course of treatment and the additional costs associated with that care. By defining these requests as urgent care requests, treatment decision may be made in a timely and appropriate manner. It is important to note that Section 2(c)(1)(B) merely affirms federal law for urgent concurrent review requests, by requiring that insurers render decisions within 24 hours of receiving such a request, and that the timing of the request has no bearing on the merit of the request for services itself.

The requirement that an appropriate clinical peer render all levels of adverse determination appropriately obliges carriers to honor their contractual and fiduciary responsibilities to their members. By ensuring that, for any adverse determination, the requested service or treatment and available clinical information has been reviewed by a clinician with relevant training and experience, consumers' requests

will receive the level of scrutiny and consideration that they are due. This principle has already been embraced by other states across the nation, including the imposition of a more vigorous peer reviewer standard in Massachusetts⁵, Rhode Island⁶ and New York⁷. The additional requirement that clinical reviewers possess specific experience and training in age appropriate substance use treatment methodology reinforces this principle and merely codifies that substance use and associated co-morbidities are unique diagnoses and deserve clinically appropriate consideration.

HB 6557 also expands consumer protections by requiring that a standard and appropriate set of clinical criteria be used for all substance use and co-morbid utilization reviews. By providing a statutory standard definition, carriers, provider and, most importantly, consumers can know how treatment requests are to be assessed. By linking these standard measures to the widely accepted and clinically appropriate American Society for Addiction Medicine's Patient Placement Criteria, or alternate criteria approved by Department of Mental Health and Addiction Services and the Department of Children and Families, requests for treatment for substance use and associated co-morbidities will at last be assessed with standard and clinically appropriate criteria by an experienced and clinically appropriate provider.

Finally, by enhancing the notice to consumers about assistance available to them, as well as the opportunities for appealing the adverse determination and their chance of success, the utilization review process becomes somewhat less mysterious, empowering consumers.

Thank you for providing me the opportunity to deliver OHA's testimony today. We look forward to continuing to collaborate and advocate for the consumers of Connecticut in this matter. If you have any questions concerning my testimony, please feel free to contact me at victoria.veltri@ct.gov.

¹ http://www.ct.gov/oha/lib/oha/documents/publications/report_of_findings_and_recs_on_oha_hearing_1-2-13.pdf

² http://www.nami.org/Template.cfm?Section=PolicyMakers_Toolkit&Template=/ContentManagement/ContentDisplay.cfm&ContentID=19043

³ http://www.nimh.nih.gov/about/director/2011/the-global-cost-of-mental-illness.shtml?WT.mc_id=rss

⁴ <http://www.politifact.com/ohio/statements/2013/jan/02/terry-russell/nami-ohio-leader-terry-russell-says-people-mental-/>

⁵ M.G.L. ch. 1760, § 12.

⁶ R.I.G.L. § 23-17.12-9

⁷ Art. 49, Title 1, §4900

