Testimony of Ted Doolittle
Office of the Healthcare Advocate
Before the Insurance and Real Estate Committee
In Support of SB 384
March 6, 2018

Good afternoon, Senator Larson, Senator Kelly, Representative Scanlon, Representative Sampson, and members of the Insurance and Real Estate Committee. For the record, I am Ted Doolittle, Healthcare Advocate. The Office of the Healthcare Advocate ("OHA") is an independent state agency with a three-fold mission: assuring consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

I appreciate the opportunity to comment on SB 384, AAC Mental Health Parity, Data Reported By Managed Care Organizations and the All-Payer Claims Database. This important bill would dramatically enhance Connecticut's ability to proactively identify and address inequities in the delivery of mental health services compared to medical services which, it is important to note, is required under federal and state law. By expanding the scope of the data insurers must report to the Connecticut Insurance Department (CID) annually to include more detailed mental health data, the state may more effectively identify trends suggestive of non-compliance with mental health parity.

This is critically important, because one of every five Americans has a mental health disorder, with higher rates among children and young adults. Of these, less than half receive treatment, and for young adults, that number drops to only about one-third. Nearly one in ten Americans struggle with substance use disorder (SUD) and, of those, 40%

struggle with both SUD and an underlying mental illness. In many cases, people do not receive treatment simply because they cannot afford it, citing the cost of care as prohibitive, even among those with insurance.

The annual impact of the behavioral health crisis on the U.S. economy is conservatively estimated to be at least $300 billion, and estimates of the impact on individuals exceed $400 billion. It's clear that costs are significant, but given the complexity of this issue, stigma, inconsistent data collection and reporting, and wildly varying consumer access and experience, efforts to gain clear insights into the economic impact on Connecticut is difficult to know. However, given that most analysis about the efficacy and cost of behavioral health treatment relies on claim data that cannot incorporate the significant number of people who seek and receive, or are unable to receive, treatment outside of traditional payment systems, it is reasonable to presume that the impact and costs could be much higher. One unfortunate indicator of the severity and urgency of this crisis in Connecticut comes from the Medical Examiner, who reported yet another annual increase in drug-related deaths in 2017, with an average of three people continuing to die every day from substance use.

Despite continuing attention and efforts at all levels of the behavioral health care system and within government to address this continuing crisis, timely access to effective and affordable behavioral health care remains a challenge. Inequity in access to behavioral health services, compared to consumers' experience accessing medical services, persists, with little variation based on income, although whites utilize behavioral health services at a significantly higher rate than minorities, even at very low income levels.

Cognizant of the unique barriers those with behavioral health care needs face, policy makers have championed initiatives to promote equitable access for those with behavioral health care needs. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) codified the principle that any health insurance plan offering behavioral health benefits which, under the Affordable Care Act, most plans must now do, must provide those benefits in a substantially similar manner to the medical benefits offered under the plan. This law sets forth a blueprint for evaluating compliance with MHPAEA, but given the inherent complexity of behavioral health care services, precise oversight has remained elusive. Although Connecticut is widely considered to be a leader in parity, in part due to the proactive legislation that's been enacted promoting greater clarity and transparency in

behavioral health benefit design and utilization review, consumers and providers continue to report barriers to treatment. The only official parity analysis/oversight in the state is the CID's Mental Health Parity Compliance Survey. While more than most other states are doing, this tool is functionally no more than a survey of the carriers, merely requiring that they self-report an assessment of whether or not they are in compliance with parity rules. Certainly, the Survey, while a good start, provides little granular data about mental health parity, and is not reported publically. The CID notes that, in its role as state regulator, "if a pattern of noncompliance [with parity] is detected through multiple complaints", they will investigate. However, this is a reactive system. In order for the CID to know what to investigate, consumers need to complain, and it is not clear that consumers have a clear idea about their rights and the carriers' responsibilities under mental health parity.

In order to effectively understand the origin of these barriers, we need more detailed data about the consumer experience. Milliman recently released the results of the most exhaustive study of behavioral health utilization and experience that's been done to date, with claim data for 42 million consumers over three years, and the results are discouraging. Despite having MHPAEA as the legal framework for crafting and providing equitable coverage for and access to behavioral health care services for ten years, and the CID's annual Parity Compliance Survey identifying no deficiencies in the provision of these benefits, the Milliman report provides a startling contrast to the presumption that Connecticut is a national parity leader. Instead, the report demonstrated unsettling patterns in the areas explored – member utilization of out-of-network versus in-network PCPs, Specialists and Behavioral Health providers, and a comparison of reimbursement.

What the claim data showed was that for insured consumers in an <u>inpatient setting</u>, people were receiving behavioral health treatment on an out-of-network basis (and thus at much greater cost) 8.63 times more often than they received in-network care in 2013, and a shocking 66.6 times more often in 2015. Connecticut was the second worst in the nation for this measure. For people receiving treatment in an <u>outpatient setting</u>, Connecticut was the seventh worst, with out-of-network facilities being utilized 11 times more often than in-network facilities in 2015. For <u>routine office visits,</u> which includes ongoing therapy that many people receive, Connecticut had the worst record in the nation, with 34.2% of the insured receiving these services out-of-network in 2015, compared to 3.3% of PCP and 4.3% of specialist visits. Undoubtedly, many people will choose to use an out-of-network provider for personal reasons, but the gross disparity in actual utilization belies an

underlying access issue that consumers and providers have reported for years – and certainly this situation can in no way be defined as "parity."

Milliman's review of in-network reimbursement rates provides some insight into this discrepancy, consistently demonstrating a 20%-30% lower reimbursement rate for behavioral health providers than what PCPs and specialists received. This inequity makes it far more difficult for behavioral health providers to agree to these rates as an in-network provider and remain financially solvent, a refrain that advocates hear from the provider community regularly.

In light of the concerns identified in Milliman's analysis of behavioral health claim data, which suggests that Connecticut's behavioral health care system is not in fact delivering actual compliance with parity, it is clear the Connecticut once again needs to make improvements to take its rightful place as a leader. SB 384 represents common sense policy that expands upon the strides we have already made to promote true parity. Especially in the context of the unimaginable financial, social, emotional and personal costs that people are burdened with in pursuit treatment that, under the terms of the contract with their insurer, they are entitled to receive with little or no difference from the medical treatment they receive, this is a moral as much as a legal mandate.

Thank you very much for your consideration of this testimony for this important bills championing transparency and consumer protections. If you have any questions concerning our position on this issue, please feel free to contact me at Ted.Doolittle@ct.gov.