TESTIMONY OF MARGARET WATT, CO-DIRECTOR, THE HUB, BEFORE THE INSURANCE COMMITTEE

FEBRUARY 27, 2020

IN SUPPORT OF:

- HB5248 AN ACT ESTABLISHING A TASK FORCE TO STUDY HEALTH INSURANCE COVERAGE FOR PEER SUPPORT SERVICES IN THE STATE.
- HB5250 AN ACT PROHIBITING REQUIREMENTS FOR PRESCRIBING CLINICALLY INAPPROPRIATE QUANTITIES OF OUTPATIENT PSYCHOTROPIC DRUGS.
- HB5254 AN ACT REQUIRING HEALTH INSURANCE COVERAGE FOR MEDICATION-ASSISTED TREATMENT FOR OPIOID USE DISORDER.
- HB5256 AAC REQUIRED HEALTH INSURANCE COVERAGE FOR DETOXIFICATION AND SUBSTANCE ABUSE SERVICES.
- HB5247 AAC EXPLANATIONS OF BENEFITS.

Senator Lesser, Rep. Scanlon, and distinguished members of the Insurance Committee:

I am the co-director of The Hub, which is the state-designated Regional Behavioral Health Action Organization (RBHAO) serving Southwestern CT. The RBHAO's role is to serve as a strategic community partner for behavioral health prevention, treatment, and recovery by assessing regional needs and providing advisory, coordination, advocacy and educational support in the areas of mental illness, suicide, substance misuse, and problem gambling. As such, I very much appreciate the Committee's work to address the serious challenges facing individuals in our state who require behavioral health services.

I very much regret that I cannot be present at today's hearing due to several prior commitments, but I am writing in support of the above-mentioned bills and to make suggestions regarding the peer support services bill.

HB5248:

I support the creation of a task force to study the issue of coverage for peer support services. We have brought forward previous bills on this important topic since certified peer support provides value and dignity to both the client and the peer specialist; has demonstrated quality and effectiveness; has shown impact in terms of reducing hospitalization and maintaining recovery; is cost effective; and provides employment to peers. (See our fact sheet here.) However, despite interest from many parties (including peers, providers, and legislators) and a number of attempts to flesh out the details, we have not yet come close to a consensus among the various stakeholders. A task force may provide the structure for that to happen.

My two **hesitations** have to do with how the task force would be formed. The current bill language does not specify the stakeholders who should be involved, which runs the risk of task force members being appointed who are not knowledgeable or who do not represent the full gamut of perspectives. The task force members should at a minimum include peers; agencies that train peers; behavioral health providers; hospitals; insurance companies….. The current bill language does, however, specify a number of legislators who would be required to each appoint a certain number of people. I was previously

involved with a bill to create a task force to make recommendations to address gaps in the psychiatric workforce. The requirement for specified professional roles to be filled by specific legislators lengthened the process of nominating members *past* the due date for the task force's report!

Recommendation: If it is possible to simply identify the minimum key stakeholder groups to be named to the task force without saying who will appoint whom, that would accomplish two things: (1) Ensure that representatives from the key stakeholder groups are appointed. (2) Reduce the time needed to get the task force going.

HB5250:

This bill would allow (but not require) prescribers to prescribe smaller quantities of psychotropic drugs when they deem it necessary. People with severe mental illness who do not react well to medications and whose prescriptions are frequently being changed can, as a result, have 90-day supplies of unused meds in their cabinet. This contributes to the risk of diversion and misuse by others who have access to the cabinet. The state has been making enormous efforts to reduce prescription of opioids in order to curb the opioid epidemic, but psychotropic medications can also have the potential for abuse and addiction so why not apply the same principle? There is a particular risk among individuals who are frequently suicidal, since by virtue of their mental illness they are likely to be prescribed psychotropic drugs such as antianxiety drugs or antidepressants. I know people personally who are concerned about the suicidal risk inherent in their access to these drugs when they are feeling particularly vulnerable.

HB5254:

This bill responds to the urgent need for Medication-Assisted Treatment (MAT) to address opioid use disorder. In a 2016 policy factsheet, Pew Trusts summarized MAT as *"**the most effective intervention to treat opioid use disorder** (OUD) and is more effective than either behavioral interventions or medication alone.[2] MAT significantly reduces illicit opioid use compared with nondrug approaches,[3] and increased access to these therapies can reduce overdose fatalities.[4] **However, MAT is often unavailable to those in need of it because of inadequate funding for treatment programs** and a lack of qualified providers who can deliver these therapies.[5]"* Last year the CGA passed the Behavioral Health Parity bill in order to ensure equal insurance coverage for substance use, mental health and physical health conditions. When people with a physical disorder such as diabetes need medication-assisted treatment (i.e., insulin) to sustain recovery, that is covered without question. So too should MAT be covered for opioid use disorders.

HB5256:

This bill appears to have a similar goal in terms of protecting individuals who are seeking detox and rehab services for a substance use disorder by ensuring that there are minimum lengths of time for treatment. In our regional needs assessments (conducted biannually with interim updates), the need for longer-term addiction treatment programs is regularly cited by community members and providers. The barrier is always financial—whether insurance coverage in private settings or state funding in public. The National Institute on Drug Use (NIDA) reports: *"Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment. Recovery from drug addiction is a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug*

abuse can occur and should signal a need for treatment to be reinstated or adjusted." The proposed bill reflects NIDA's statement.

HB5247:

This bill provides consumers with information related to their healthcare benefits, but more importantly it provides important protections to the behavioral health community. We commonly hear of struggles in families where one covered adult has a behavioral health disorder and the other adult (naturally) wants to know what treatment is being provided through their insurance. However, HIPAA privacy requirements are clear that a healthcare provider can only discuss protected medical information with another family member when there is prior consent. I see the proposed legislation as aligning with this HIPAA requirement because it allows the covered adult to determine whether and to whom Explanations of Benefits are provided. This is an important protection in families where one individual needs some type of treatment (e.g., trauma, domestic violence, substance abuse, gender reassignment) and does not want another family member to know it, because fear that others will find out can sometimes prevent the person from getting needed help.

Thank you again for raising these bills in support of the behavioral health community!

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