

Committee
Report

Access to Substance Use Treatment for Youth: Phase I Appendices

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Legislative Program Review
& Investigations Committee

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Acronyms

ACA	Patient Protection and Affordable Care Act of 2010
AG	Office of the Attorney General
ASAM	American Society for Addiction Medicine
ASAM PPC-2R	<i>American Society for Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised</i> (i.e., the ASAM manual)
ASO	Administrative services organization (for health insurance)
BHP	Behavioral Health Partnership (handles mental health and substance use care for enrollees of all CT Medicaid programs, certain DCF Voluntary Services, and Charter Oak Health Plan)
CID	Connecticut Insurance Department
CMS	Centers for Medicare & Medicaid Services (federal)
DCF	Department of Children & Families
DMHAS	Department of Mental Health and Addiction Services
DSM	<i>Diagnostic and Statistical Manual of Mental Disorders</i>
DSS	Department of Social Services
EBSA	Employee Benefits Security Administration (part of the U.S. D.O.L.)
ERISA	Employee Retirement Income Security Act
HHS	Department of Health and Human Services (federal)
HUSKY	Connecticut's Medicaid programs (HUSKY A through D)
IRO	Independent review organization
LIA	Medicaid for Low-Income Adults (replaced SAGA medical assistance in 2010); is now HUSKY D
MHPAEA	Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
NAIC	National Association of Insurance Commissioners
OHA	Office of the Healthcare Advocate
SAGA	State-Administered General Assistance

Study Methods

The report draws upon a variety of information sources. Program review committee staff had extensive conversations with: youth in recovery, and parents of some; substance use treatment providers; private insurance staff and representatives; personnel from numerous state agencies and offices - the Insurance Department, the Department of Social Services, the Department of Mental Health and Addiction Services, the Department of Children and Families, the Office of the Attorney General, and the Office of the Healthcare Advocate (OHA) - as well as staff from the Behavioral Health Partnership (BHP) administrative services organization; legal aid attorneys; national substance use treatment advocates; and researchers. These conversations, as well as the study's June 2012 public hearing and the OHA-sponsored October 2012 hearing on mental health parity, informed all aspects of this report.

For information on behavioral health coverage in plans and the extent to which requests for treatment are denied by insurers, committee staff acquired and then analyzed information from the state's fully-insured private health plans (which are under the purview of Connecticut's insurance laws) and BHP. In addition, committee staff surveyed practitioners.¹ For information on state oversight of health plans and the state's external review process, data and information from the state offices were examined.²

For an understanding of mental health parity laws, as well as utilization review requirements in other states, committee staff reviewed state and federal laws, examined federal agency websites, and communicated with other states' executive branch staff involved in utilization review regulation.

Finally, for information on the extent of substance use, treatment options, and related topics, committee staff reviewed federal agency websites, academic articles, and policy reports.

¹ Surveys of private counseling practices, licensed substance use treatment facilities, and colleges were also conducted. The results will be incorporated into the study's second report.

² Committee staff requested but did not receive information and data from federal agencies to learn how self-insured plans' compliance with mental health parity laws is monitored. Data from the Office of the State Comptroller was requested to examine treatment requests for the State Employee Health Plan, but the information was provided too late for inclusion in this report.

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Mental Health Parity Laws: Details

Connecticut's Law

History. Connecticut's current parity law, in effect since 2000, replaced and expanded on a 1997 law that was part of a broader managed care regulation effort. The 1997 law granted parity to a limited number of mental conditions for enrollees of group and individual insurance policies, and did not extend to substance use disorders.

Before the 1997 parity law, Connecticut insurance requirements differed for substance use and mental health benefits. Group insurance policies were required to provide at least 45 days per year (either calendar, or within 12 months from first admission date) of coverage for inpatient and residential substance use care. The corresponding requirement for mental health care was 60 days annually; there was also a calendar-year 120-session floor on partial hospitalization benefits. Outpatient substance use coverage was required to be *offered* by carriers to employers using fully-funded plans, but there was no mandated benefit or required amount. In contrast, outpatient mental health care was required to be covered up to at least \$2,000 annually.³

Federal Laws

Current status of 2008 law. The 2008 federal parity law laid out a framework for determining whether parity between behavioral health and medical coverage exists, but many details are still awaited. An interim rule was issued in February 2010; a final rule is in development. The interim regulation is enforceable, with a few minor adjustments.⁴ Federal agencies, advocates, and health insurance carriers continue to debate what should be acceptable or expected under the mental health parity law.

In February 2012, the U.S. Department of Health and Human Services' (HHS') planning and evaluation office issued a contracted RAND Corporation report exploring implementation issues that seem to indicate a need for further clarity or adjustments. As a method of gathering information, the researchers convened a panel of behavioral health managed care experts (both employed by health plan carriers and not). The panel members noted that several factors could be examined to determine whether different types of non-quantitative treatment limitations are reasonable, including:

- “evidence of clinical efficacy;

³ From the Jan. 1, 1997 statutes: C.G.S. Sec. 38a-514 for mental health care ; C.G.S. Sec. 38a-539(b) for outpatient substance use care; and C.G.S. Sec. 38a-533(b) for inpatient and residential substance use care.

⁴ Plans will not face federal enforcement action on outpatient benefit quantitative parity violations if the “predominant / substantially all” test is met for two sub-classifications: office visits, and “all other outpatient items and services. (“Self-Compliance Tool for Part 7 of ERISA: HIPAA and Other Health Care-Related Provisions,” U.S. Department of Labor. Accessed October 12, 2012 at: <http://www.dol.gov/ebsa/pdf/cagappa.pdf>.)

- diagnostic uncertainties;
- unexplained rising costs,...
- availability of alternative treatments with different costs...
- evidence of inconsistent adherence to established practice guidelines...[and]
- high variation in practice.”

Under the rules, these and other factors should be evaluated equally for medical/surgical and behavioral health managed care practices, although the evaluations might not reach comparable *results* for the categories of care. The panel’s discussion further indicated that clarification might be needed regarding:

- how to categorize intensive outpatient and partial hospitalization care – as outpatient, inpatient, or another category (and if the last, what the comparison basis should be); and
- network admission requirements – specifically, whether supervised experience is necessary for masters-level clinicians.^{5,6}

Some behavioral health access proponents believe the current laws and rules are insufficient – and/or insufficiently enforced – to ensure adequate, meaningful mental health and substance use treatment coverage. They have formed a Parity Implementation Coalition. The group in 2012 has held seven hearings in states across the country, at which clients, providers, and advocates shared stories and rallied for expansive parity rules. Connecticut’s healthcare advocate has participated in the coalition and arranged one of the hearings, in October.

On the other hand, some carriers have voiced dissatisfaction with or found burdensome the final rule’s provisions. A spring 2010 *The New York Times* article stated that insurers and many employers feel the rules would result in cost increases for both plans and patients.⁷ Logistically, making the rule’s required comparisons between behavioral health and medical benefits has been difficult for some managed behavioral health organization carve-outs.⁸

⁵ A subsequent document from the U.S. Department of Labor (the compliance tool referenced above) indicates that requiring master’s level clinicians complete supervised experience before network admission does not violate parity because licensed medical/surgical master’s level practitioners must have that experience as part of their training.

⁶ "Short-term Analysis to Support Mental Health and Substance Use Disorder Parity Implementation," M. Susan Ridgely, Rosalie Liccardo Pacula, and M. Audrey Burnam; RAND Corporation for the U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation, February 2012. Accessed June 4, 2012 at: <http://aspe.hhs.gov/daltcp/reports/2012/mhsud.pdf>.

⁷ "Fight Erupts Over Rules Issued for ‘Mental Health Parity’ Insurance Law," Robert Pear, *The New York Times*, May 9, 2010.

⁸ "Short-term Analysis to Support Mental Health and Substance Use Disorder Parity Implementation," M. Susan Ridgely, Rosalie Liccardo Pacula, and M. Audrey Burnam; RAND Corporation for the U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation, February 2012. Accessed June 4, 2012 at: <http://aspe.hhs.gov/daltcp/reports/2012/mhsud.pdf>.

Certain carriers have suggested that at least some behavioral health care services are not comparable to medical/surgical services. For example, in the HHS expert panel, one carrier stated outpatient psychotherapy has greater potential for misuse than outpatient medical care because:

- “(1) existing guidelines are not specific;
- (2) clinician training and standards, especially for masters-level therapists, are diverse, so therapists may not have appropriate skills; and
- (3) there is no way to know what goes on in psychotherapy (e.g., what specific therapeutic approaches and techniques are used).”⁹

The panel suggested that outpatient psychotherapy provisions be evaluated for compliance against physical therapy. Similar concerns and viewpoints were voiced by insurer personnel during a conversation with program review committee staff.

Impact of 2008 law. A U.S. Government Accountability Office study provided some indication that the 2008 parity law and the accompanying regulation has had a very little overall impact on the inclusion of behavioral health coverage in large group employer plans. Study survey respondents indicated nearly all (96 percent) had offered behavioral health benefits before and after the law. Only two percent of plans had dropped either mental health or substance use coverage since the law and regulation took effect. Other components of behavioral health coverage – cost-sharing and lifetime coverage limits – also appear not to have been adversely affected (from an enrollee’s perspective) by the mental health parity law. There may, however, have been a slight rise in the percent of employers whose plans exclude from coverage at least one behavioral health diagnosis (from 34 percent in 2008 to 39 percent in 2011, according to the survey data).¹⁰

Expansion through the ACA. The ACA expands both what and who is covered by the federal parity laws. The ACA’s various provisions mandate mental health and substance use coverage and extend the federal parity law protections, by January 1, 2014, for these plans:

- qualified health plans (as established by the ACA), which are among those that may be offered in (or out) of the state health plan exchanges;
- Medicaid non-managed care benchmark¹¹ and benchmark-equivalent plans;¹² and

⁹ "Short-term Analysis to Support Mental Health and Substance Use Disorder Parity Implementation," M. Susan Ridgely, Rosalie Liccardo Pacula, and M. Audrey Burnam; RAND Corporation for the U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation, February 2012. Accessed June 4, 2012 at: <http://aspe.hhs.gov/daltcp/reports/2012/mhsud.pdf>

¹⁰ *Employers’ Insurance Coverage Maintained or Enhanced Since Parity Act, but Effect of Coverage on Enrollees Varied*, U.S. Government Accountability Office, November 2011. Accessed June 4, 2012 at: <http://www.gao.gov/assets/590/586550.pdf>.

¹¹ Under the ACA, certain Medicaid groups can be offered enrollment in plans specifically designed or intended for them. These are called benchmark or benchmark-equivalent plans. Specific government employee and commercial

- new individual plans.¹³

The ACA also extends the reach of the federal parity laws to all individual plans, and mandates mental health and substance use benefits for new small group plans, except those that are self-insured.

These changes mainly result from the inclusion of mental health, substance use disorder, and behavioral health benefits as, collectively, one of the ten categories of essential health benefits. The essential health benefits package must be offered by insurers that offer new individual and small group plans, either within or outside the state exchanges, as well as by all Medicaid plans.¹⁴ The exact services within the package's categories will vary among states and possibly even plans within a state.¹⁵

The ACA's essential health benefits provisions also ultimately prohibit spending limits for mental health and substance use disorder benefits, for any plan. Lifetime and annual insurer spending limits for any category within the package are to be removed, for plan years beginning September 2010 (unless grandfathered) and January 2014, respectively.¹⁶

The essential health benefits package and the exchanges aim to improve the depth and affordability of individual and small group plans, while reducing the percentage of those uninsured. In Connecticut, individual plans covered about five percent of the nonelderly population in 2009-10, while 13 percent were uninsured; the coverage under small group plans was unavailable.¹⁷

plans are designated as these. ("Benchmark Benefits," Medicaid.gov. Accessed December 10, 2012 at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Benchmark-Benefits.html>.)

¹² It is unclear exactly how or even if the parity laws apply to these plans, for two reasons. First, the ACA appears to apply only those parity prohibitions against treatment limitations and financial requirements. Second, these plans are deemed to meet parity requirements if they offer Early Periodic Screening and Diagnostic Treatment (EPSDT) services, which by law they must do. (Source: Sarata Congressional Research Service article below)

¹³ Amanda K. Sarata, Congressional Research Service, "Mental Health Parity and the Patient Protection and Affordable Care Act of 2010." Accessed May 31, 2012 at: <http://www.ncsl.org/documents/health/MHparity&mandates.pdf>.

¹⁴ "Essential Health Benefits: HHS Informational Bulletin." Accessed May 31, 2012 at: <http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>.

¹⁵ "Essential Health Benefits," Health Policy Brief, *Health Affairs*, April 25, 2012. Accessed May 31, 2012 at: http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=68. A state would have to pay for any "extra" coverage required by state law in its essential health benefits package, for those enrolled in plans through the exchange.

¹⁶ "Glossary: Essential Health Benefits." Accessed May 31, 2012 at: <http://www.healthcare.gov/glossary/e/essential.html>.

¹⁷ "Health Insurance Coverage of Nonelderly 0-64, states (2009-2010), U.S. (2010)," The Henry J. Kaiser Family Foundation. Accessed June 4, 2012 at: <http://statehealthfacts.org>.

Appendix C

Connecticut Medicaid (BHP) & Fully-Insured Plan Coverage of Substance Use Treatment

Table C-1. Behavioral Health Partnership (BHP) Participating Programs			
<i>Program</i>	<i>Population</i>	<i>Income Level as % of Federal Poverty Level</i>	<i>Cost-Sharing?</i>
Charter Oak Health Plan	1. Not qualified for public insurance 2. Uninsured for at least six months 3. Ineligible for CT Pre-Existing Condition Insurance Plan	Not a criterion (except as relates to eligibility for HUSKY, as below)	Yes
DCF Limited Benefit	Ineligible for HUSKY but DCF-involved ^a	Not a criterion	No
HUSKY A	Children (<19) and parent(s)/ relative caregiver(s); pregnant women	0 to 185% (0 to 250% for Pregnant Women)	No
HUSKY B	Children (<19)	185 to 300% ^b	Yes
HUSKY C	Aged, blind, disabled (a.k.a. Title 19)	0 to 56% (68% in Region A) ^c	No
HUSKY D	Medicaid Low Income Adults (LIA - previously SAGA Medical)	0 to 56% (68% in Region A) ^c	No
^a DCF-involved in any way: child protection, Voluntary Services, or juvenile justice. Only one type of BHP services – an in-home treatment model known as IICAPS – is available under the Limited Benefit. ^b Unsubsidized coverage is available if family income is over 300% of the federal poverty level. ^c Region A is mostly located in Southwest Connecticut. Sources: DSS; “Medicaid for Low-Income Adults and Charter Oak Health Plan,” OLR Research Report, Robin K. Cohen, June 24, 2011.			

Table C-2. Types of Substance Use Treatment Covered by Certain Major Connecticut Health Plans, 2012						
	<i>Commercial Fully-Insured</i>					<i>Medicaid (BHP)</i>
	<i>A</i>	<i>B</i>	<i>C</i>	<i>D</i>	<i>E</i>	
Inpatient (generally detox.)	✓	✓	✓	✓	✓	✓
Residential rehabilitation	✓	✓	✓	✓	✓	Only HUSKY A,B, & (covered by DMHAS) D only
Community living arrangement (e.g., halfway house)				*		HUSKY D (covered by DMHAS)
Wilderness programs						
Partial hospitalization	✓	✓	✓	✓	✓	✓
Intensive outpatient	✓	✓	✓	✓	✓	✓
Outpatient (in-office)	✓	✓	✓	✓	✓	✓
In-home treatment models						✓**
<p>*Plan D noted that while the housing and related costs of a community living arrangement would not be covered, the treatment offered by such a program would be.</p> <p>**MDFT is not available to Charter Oak Health Plan members, and IICAPS is available to BHP enrollees under 21.</p> <p>Source: PRI staff analysis of information provided by the CT Association of Health Plans and DSS.</p>						

Table C-3. Preauthorization Required for Various Types of Substance Use Treatment Covered by Certain Major Connecticut Health Plans, 2012

	<i>Commercial Fully-Insured</i>					<i>Medicaid (BHP)</i>
	<i>A</i>	<i>B</i>	<i>C</i>	<i>D</i>	<i>E</i>	
Inpatient	✓*	✓	✓	✓	✓	✓
Residential	✓*	✓	✓	✓	✓	✓
Community living arrangement (e.g., halfway house)	---	---	---	---	---	✓
Partial hospitalization	*	✓	✓	✓	✓	✓
Intensive outpatient	*	✓	✓	✓	✓***	✓
Outpatient (in-office, non-detox)	*	**	No	IF: Out-of-network / visit >50 min.	✓***	Registration ****
Outpatient detox.	✓	✓	✓	Same as above	✓***	Registration
In-home treatment models	---	---	---	---	---	Registration

*Plan A stated that while prior authorization requirements for the levels of treatment vary among its fully-insured plans, they are generally in place for facility care and non-routine outpatient services.
**Plan B routine outpatient services do not require prior authorization.
***Plan E noted employers can choose whether to extent preauthorization requirement to outpatient services (below the level of partial hospitalization).
****Registration means that preauthorization is handled through the administrative services organization's online system, instead of through telephone calls.
Source: PRI staff analysis of information provided by the CT Association of Health Plans and DSS.

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History of Connecticut & Federal Utilization Review Laws

While individual plans come under state insurance law, fully insured employer group plans are subject to both that and the applicable federal law, the Employee Retirement Income Security Act (ERISA) of 1974. Self-insured employer plans excluding government plans were, before the 2010 Affordable Care Act (ACA), governed solely by ERISA. Prior to the ACA, then, some utilization review requirements varied depending on whether the plan was subject to state utilization review law or ERISA.

ERISA's claims procedures provisions apply to health plan utilization review and all other employer-related welfare benefits claims (e.g., retirement, disability). The procedures were updated - for the first time since ERISA's adoption - by a rule (i.e., regulation) that became effective in 2003. The changes collectively aimed to make group health and disability plan decisions quicker, more open to enrollees, and subject to a "full and fair" internal appeals process. No external review process, however, was put in place; a self-insured enrollee dissatisfied with a health plan decision had no recourse outside court or, if provided in the plan, arbitration.

Connecticut, meanwhile, first began to regulate health plan utilization review in 1991, under P.A. 91-305, covering fully-insured individual and group plans. Procedures, timelines, oversight, and other aspects of utilization review were addressed. Greater consumer protections, including an external appeals process (outside the review company or insurer) were put in place by a broad managed care reform bill, P.A. 97-99. Additional protections, such as requirements to include in a denial notice the reason and the external appeal application, and extension of utilization review requirements to managed care organizations and insurers were put in place over the years, particularly through a few 2005 public acts.¹⁸

Recent changes. The Affordable Care Act addressed utilization review and appeals as part of its consumer protections. Section 2719 requires group plans and issuers offering group or individual coverage (i.e., effectively all private plans) to have utilization review processes that, at a minimum, include:

- an internal claims appeal process;
- understandable notice to enrollees of available internal and external appeals processes, and health insurance consumer assistance;
- an ability for an enrollee to review the file, present evidence, and argue as part of the appeals process, and receive coverage pending the appeals outcome; and

¹⁸ Public Acts 05-94, 05-97 and 05-102.

- an external review process that has the consumer protections in the National Association of Insurance Commissioners’ Uniform Health Carrier External Review Model Act (i.e., the NAIC Model Act).

The U.S. Departments of Health and Human Services, Labor, and the Treasury issued interim final rules for this section of the ACA on July 23, 2010,¹⁹ with subsequent guidance in August 2010, amendment in June 2011, and correction to the amendment in July 2011.²⁰ These regulations and various provisions of the ACA:

- made a few changes to the ERISA claims and internal appeals requirements, in favor of greater disclosure and, in certain circumstances, quicker decisions;
- applied those changes and the relevant portions of ERISA to individual health plans (i.e., those purchased by individuals instead of offered by employers); and
- made available an external appeals process for all non-grandfathered plans, creating federal processes for self-insured plans and people whose states’ processes fall short of the NAIC Model Act.

The ACA’s reforms in these areas are a “floor.” States may choose to implement procedures that include greater enrollee protections, for those plans governed also by state law (i.e., fully insured and individual).

Connecticut responded to subsequent direct instruction from the federal government by essentially adopting the provisions in the regulations and the NAIC Model Act, through Public Act (P.A.) 11-58.²¹ The utilization review and appeals requirements were substantially changed – generally to the enrollee’s benefit – particularly with additions of internal appeals timeframes, the extension of the external review filing period, and new notification requirements. A few additional, smaller alterations, to increase the information available to the enrollee and his/her advocate(s), made by P.A. 12-102 became effective October 1, 2012. Consequently, people enrolled in Connecticut group and individual health plans now have similar utilization review and external appeals procedures.

¹⁹ Federal Register, Friday, July 23, 2010. Part IV. Department of the Treasury, Internal Revenue Service: 26 CFR Parts 54 and 602. Department of Labor, Employee Benefits Security Administration: 29 CFR Part 2590. Department of Health and Human Services: 45 CFR Part 147.

²⁰ Federal Register, Tuesday, July 26, 2011. Volume 76, Number 143.

²¹ Testimony of the Connecticut Insurance Department Before the Connecticut General Assembly's Insurance and Real Estate Committee, March 15, 2011 on SB 1158

Commercial Plan Utilization Review Process: Details

Initial Determinations

Timeframes. The decision timeframes vary according to the type of utilization review. Prospective and concurrent review maximum times until a decision are 15 days, unless the situation is urgent (i.e., requires expedited review). A retrospective review decision must be made within 30 days. One extension of up to 15 days is possible if the carrier or utilization review company experiences circumstances beyond its control and notifies the enrollee of the extension, as well as the reason(s) for it (e.g., insufficient information given).²²

Table E-1. Utilization Review Timeframes (in calendar days, except where noted) for Fully-Insured Plans in Connecticut and Nearby States					
	<i>Massachusetts</i>	<i>New Jersey</i>	<i>New York</i>	<i>Rhode Island</i>	<i>Connecticut</i>
Initial Decision					
Prospective	2 (bus.) + 1	15	3 (bus.)	15 (bus.)	15
Prospective – Expedited	2 (bus.) + 1 ^a	3	3 (bus.)	3	3
Concurrent	2	1	1 (bus.)	---	3 (exped.) or 15
Retrospective	2 (bus.) + 1 ^a	30	30	30 (bus.)	30
Internal Appeal					
File request	180 ^a	180	45 ^f	60 ^f	180
Decision	30 (bus.) ^b	10	30 ^c	15 (bus.)	30
Decision – Expedited	2	3	2 (bus.) ^d	2 (bus.)	3
External Appeal					
File request	4 mos.	4 mos.	4 mos. ^e	2 mos. ^f	4 mos.
Decision	60	45	30	10 (bus.)	45
Decision – Expedited	4 (bus.)	2	3	2 (bus.)	3
<p>Notes: When the law specified two separate timeframes for making a decision and providing notification to the provider (as in Massachusetts), the two were combined. Regarding the chart's information: “(bus.)” indicates business days; “mos.” indicates months; numbers with no identifiers are calendar days.</p> <p>^a State law does not explicitly address any of these aspects. Proper interpretation was verified with appropriate state agency staff.</p> <p>^b If the patient is terminally ill, a decision and notification must be made within five days.</p> <p>^c If the request was retrospective or for an individual plan, then the timeframe is 60 days. If the request was concurrent, then two business days are allowed</p> <p>^d For employer plans, a decision must be made in the earlier of 2 business days from receipt of all information, or 72 hours. For individual plans, the decision must be made within the former period.</p> <p>^e If the provider is filing the appeal (not on behalf of the patient), then the filing timeframe is 45 days.</p> <p>^f The federal filing timeframes - 180 days for an internal appeal and four months for an external appeal - apply to employer plans in all states.</p> <p>Source of data: PRI staff review of applicable other states’ laws and regulations, and communication with Massachusetts and Rhode Island executive branch staff to clarify interpretation of law and regulation.</p>					

²² Prior to P.A. 11-58, enacted to comply with the ACA, state statute (C.G.S. Sec. 38-226a(1)) required the decision on a prospective or concurrent request be made within two business days of the receipt of all information; there was no “urgent” designation. In addition, insufficient information was grounds for an adverse determination.

Some nearby states' current utilization review timeframes for fully-insured plans are shown in the table above.²³ The table indicates that no state consistently had short timeframes (compared to the other states), and that Connecticut's timeframes are not out of line with those of nearby states.

Decision-maker level of expertise. To determine whether the lack of specific expertise allowed by Connecticut utilization review law is reasonable, program review committee staff examined the utilization review decision-maker requirements of nearby states, as well as Connecticut's medical malpractice law and external appeal decision-maker requirements (which are described further below).

Other states. The utilization review decision-maker requirements of four nearby states – Rhode Island, Massachusetts, New York, and New Jersey – were reviewed by program review committee staff. These states all mandate that even the decision-maker on the first denial must have some specific expertise or level of education, as listed below and described in the following table:

- licensure in an appropriate specialty (Massachusetts);
- licensure at the same educational level as the requesting practitioner (Massachusetts and Rhode Island);
- a physician (New Jersey); and/or
- a physician or someone who is credentialed / licensed in a similar specialty as someone who typically manages the condition or provides the requested service (New York).

²³ The sources were: Massachusetts - Laws Title 22, Chapter 1760; 105 CMR 128.000 (Health Insurance Consumer Protection); 211 CMR 52.00 (Managed Care Consume Protections and Accreditation of Carriers); and <http://www.mass.gov/eohhs/consumer/insurance/managed-care-protections/>. New York - Ins. Law s 4900; Article 49 of the Public Health Law; 11 NYCRR 410.1;and <http://www.dfs.ny.gov/insurance/extapp/extappqa.htm>; New Jersey - N.J.A.C. 11:24-8; L. 2005, c. 352; and http://www.state.nj.us/dobi/division_insurance/managedcare/index.htm. Rhode Island: R23-17.12-UR; and R.I. Department of Health Utilization Review Application Guidelines.

Table E-2. Utilization Review Decision-maker Requirements for Fully-Insured Plans in Connecticut and Nearby States

	<i>Massachusetts</i>	<i>New Jersey</i>	<i>New York</i>	<i>Rhode Island</i>	<i>Connecticut</i>
1 st Denial	Licensed in appropriate specialty and in same licensure category*	Physician	1. Licensed physician; or 2. Another professional who is: a. either licensed or similar, or credentialed by national accrediting org., and b. In same profession and same or similar specialty as the provider who typically manages the condition or provides the requested service	Same licensure status as requester	Licensed practitioner
1 st Internal Appeal	At least one level of appeal, all these: 1. Mass. license or certified by a recognized bd.	Panel with access to consultant practitioner (trained or actively practicing) in same specialty that typically manages case, or of another type if the parties agree [including with children, if applicable]		Same licensure status as requester; same reviewer okay if is new info. (<i>not allowed in others or by federal law</i>)	All these: 1. Physician or other health care professional with a nonrestricted license in a U.S. state 2. Licensure in the same or similar specialty as typically manages the medical condition, procedure, or treatment requested
2 nd Internal Appeal	2. Same or similar credentials as those who typically provide requested care and have experience in condition – including with children, if applicable 3. Actively practices**			Either: 1. Same licensure status 2. Licensed physician in same or similar general specialty as typically manages the condition / care requested	

* “Same licensure category” refers to level of education (e.g., master’s level license).

**Must practice at least part-time (i.e., cannot be full-time utilization review or insurance company staff without also engaging in part-time direct provision of health care).

Source: PRI staff review of these states’ laws and regulations, and communication with states’ executive branch staff when necessary.

Medical malpractice. Medical malpractice statutes provide that an expert witness on the prevailing standard of care is someone who meets one of these three sets of requirements (with precise match depending on the defendant's situation):

- is trained and experienced in the same specialty as a defendant practitioner, as well as certified by the appropriate specialty board;
- is licensed and in the same discipline or school of practice, with practice or teaching in the last five years; or
- has training, experience and knowledge in a related field of medicine, through teaching or practice in the last five years.²⁴

Medical necessity definition. The medical necessity definition became law through Public Act (P.A.) 07-75. C.G.S. Sec. 38a-482a and C.G.S. Sec. 38a-513c contain the same definition for individual and group policies, respectively. The text is (with formatting added for ease of reading):

... “Medically necessary” or “medical necessity” means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- (1) In accordance with generally accepted standards of medical practice; *[see below]*
- (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
- (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For the purposes of this subsection, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

Denial notice requirements of fully-insured Connecticut plans. If an adverse determination is made, notice is sent to the enrollee and provider. Per state statutes, the notice must include, among other components:

1. a specific reason for the determination and a description of the standard used, and if based on a specific internal rule, guideline, or protocol used to make the decision, a copy of that protocol or a statement that a free copy would be provided upon request;

²⁴ C.G.S. Sec. 54-184c

2. if the determination is based on medical necessity, either an explanation of the rationale applying the plan terms to the enrollee's situation, or a statement that a free copy would be provided upon request;²⁵
3. a statement that all the carrier's documents, records, information, and under P.A. 12-102 (for fully insured plans), communications and evidence, including medical journal citations, regarding the request are available free, upon request;²⁶ and
4. a description of the appeals process and statement that the person has the right to contact the insurance commissioner or healthcare advocate, with contact information listed.²⁷

Alternative considered. The program review committee considered adopting a substance use treatment law similar to Pennsylvania's. Act 106, which became law in 1986:

- mandated minimum annual coverage for inpatient, residential, partial hospitalization, and outpatient substance use disorder treatment settings;
- allowed certain lifetime coverage limits, per setting, while prohibiting less favorable cost-sharing (compared to medical care in similar classifications - e.g., inpatient) for the first round of treatment; and
- gave licensed physicians (which includes psychiatrists) and psychologists prescribing power.

Accordingly, doctoral-level health practitioners determine the setting and duration, and are the coverage authorizers; plans are not allowed to conduct utilization review based on medical necessity. While the initial law included only alcohol treatment, its sunset renewal three years later extended to all substances and made the law permanent. The legislature strongly supported and felt ownership of the law, which has helped the law endure and be fully enforced, according to a treatment provider advocate. Carriers challenged the law and its enforcement in the 2000s, but they were upheld by the state's Supreme Court in 2007 and 2009, respectively.

The committee ultimately decided not to propose this approach for Connecticut at this point in time, for a few reasons. First, as noted above, there is some indication it is may be best if even a doctoral-level practitioner has some expertise in substance use treatment.

²⁵ The 2008 federal parity law requires that the medical necessity determination criteria for mental health and substance use treatment must be made available to any current or potential beneficiary or contracting provider upon request, at any time (i.e., an adverse determination is not first required).

²⁶ Under P.A. 12-102, this information must be provided within five business days of the request when the adverse determination was made in a non-urgent situation, and within one calendar day in an urgent case or in certain other time-sensitive circumstances (e.g., person received emergency services and has not been discharged from the facility).

²⁷ C.G.S. Sec. 38a-591d(e)

Second, the Pennsylvania approach is a drastic shift away from health insurance utilization review practices, which managed care companies have touted as a way to contain costs and have become widespread.²⁸

Third, the analysis of fully-insured plan data indicated that while access to substance use treatment may be more difficult under particular carriers or for certain levels of care, the problems are not widespread and pervasive. Therefore, it may make sense to pursue the other proposed recommendations contained in the report's body and if after a few years, there was still some dissatisfaction with carriers' substance use coverage decisions, it could be appropriate for the legislature to consider changes akin to Pennsylvania's law.

Internal Appeals

In Connecticut, a commercial insurance enrollee (or the person's representative) can file an internal appeal within 180 days of receiving the decision notice. The person assigned by the carrier to decide the internal appeal cannot have been involved in the initial adverse determination.²⁹ An enrollee of a self-insured plan may find that the employer's third-party plan administrator (usually a major carrier) handles the first level internal appeal, while the employer itself – for example, its human resources staff – decides the second level internal appeal. Federal law requires that individual plans allow only one level of internal appeal before an upheld coverage denial is eligible for an external appeal.

“Medical necessity” determinations. For an appeal of an adverse determination based on “medical necessity,” the carrier must select a healthcare professional with a level of familiarity with the area of medicine involved in the appeal. Connecticut law, applicable to fully insured plans, defines this “clinical peer” as a licensed physician or other health care professional in “the same or similar specialty as typically manages the medical condition, procedure or treatment under review.”³⁰ For behavioral health cases, in practice this is a psychiatrist – not necessarily with an appropriate sub-specialty (e.g., child and adolescent psychiatry, or addiction psychiatry). Federal regulation is relatively vague regarding expertise level: “a [licensed or certified] healthcare professional with appropriate training and experience in the field of medicine involved.”

As part of the internal appeal process, the enrollee is to receive any new scientific or clinical rationale from the carrier with sufficient notice to enable the person or his/her representative a chance to respond before the decision date. A decision must be received by the enrollee within 30 days if the utilization review was prospective or concurrent, or 60 days if it

²⁸ It is unclear whether Pennsylvania's law has impacted healthcare premiums. Between 2003 and 2010 (after the Pennsylvania Supreme Court's decision to uphold the law), Pennsylvania's average premium increases for individual and family policies were nearly identical to Connecticut's. The average premium is a higher share of median household income in Pennsylvania compared to Connecticut, but only 12 other states have a share of the approximate size (or lower) of Connecticut's. (Source: "State Trends in Premiums and Deductibles, 2003-2010: The Need for Action to Address Rising Costs," C. Schoen, A.K. Fryer, S. R. Collins, and D. Radley, The Commonwealth Fund, Nov. 2012. Accessed September 7, 2012 at: http://www.commonwealthfund.org/usr_doc/site_docs/slideshows/PremiumTrends2011/PremiumTrends2011.html.)

²⁹ C.G.S. Sec. 38a-591e(c)(1)(B). Also, the ERISA regulations specify that the person must also not be subordinate to anyone involved in the initial determination.

³⁰ C.G.S. Sec. 38a-591a(7)

was retrospective. Under federal regulation, if the employer plan generally requires two internal appeals, each timeframe is halved. An expedited review is available in urgent situations; a decision is required within 72 hours of the request.

When the decision has been made, the enrollee is sent a notice (in writing or electronically) that must have the same components regarding reason and criteria as the initial adverse determination notification, as well as the steps to file an external appeal and contact relevant state government assistance.^{31, 32} Since enactment of P.A. 05-94 (effective July 1), CID has interpreted the latter provision to mean that the consumer guide to external appeals, which includes the external appeal application, must be included with final internal appeal notices.³³ Regulations that became effective September 2012 specifically require the consumer guide to be included.³⁴

Connecticut fully-insured plans. Among Connecticut carriers of fully-insured plans, some have a single level of internal appeal while others have two levels, for their group plans.

The carrier's review for the final level of internal appeal is done in one of three ways:

1. document review;
2. telephone conversation among the enrollee (or their guardian(s)), any representative of them, the enrollee's treating practitioner (if the person is asked and agrees to participate), and the carrier staff; or
3. in-person conversation, with the same participants as above (except that the treating practitioner does not participate directly).

The carrier may choose to give the decision authority to a single person or group. One carrier reported that it uses an internal panel to make second-level appeal decisions. The panel is composed of both clinical staff (including the mental health director, unless he was involved in the initial determination) and non-clinical staff, such as customer service and contracts personnel. The majority decision of the voting panel members rules, even when clinical staff disagree.

One of the carriers with only a single appeals level employs a unique method for its appeals decision-making. Non-expedited appeals are reviewed by one of its three contracted independent review organizations (which are described further below), instead of by their utilization review company's internal staff. The carrier pays the review organizations on a per-

³¹ C.G.S. Sec. 38a-591e

³² Prior to P.A. 11-58, C.G.S. Sec. 38a-226a(2)(7) required the final internal decision had to be made by a Connecticut-licensed physician, nurse, or other health practitioner (if under a physician or nurse's supervision). If a denial related to medical necessity was upheld on internal appeal, a request could be made for another internal review, this time by a specialist in the field, either a Connecticut-licensed physician or someone supervised by one.

³³ P.A. 05-94 required a denial notice to include the procedures and application for filing an external appeal. Currently the state statute requires the final denial notice to include "a statement describing the procedures for obtaining an external review of the final adverse determination" (C.G.S. Sec. 38a-591e(e)(6)(F)).

³⁴ R.C.S.A. Sec. 38a-591-8

decision basis. The carrier chose this method for handling appeals to ensure that the decision was made by strictly impartial experts, according to a conversation with committee staff.

External Appeals

Self-insured plans. Self-insured plans historically have not participated in the state external review process in large numbers because, to do so, they would have to agree that all state insurance laws are binding on them, according to the insurance department. The CID did, for a time (up to the passage of P.A. 11-58), accept municipal self-insured plans into its external review process. There was some concern that plans were not accepting the external review result. A key principle of the external review process is that, once made, a decision is binding on a plan; otherwise, the process loses integrity.

There is a single exception to the self-insured plan exclusion: enrollees in the State Employee Health Plan may pursue CID external review because the plan's overseers (the Office of the State Comptroller) agreed in a Memorandum of Understanding to follow all state insurance laws, including that an external review decision is binding. When the ACA regulations were issued, specifically allowing a self-insured plan to access an adequate state external review process, a few of those plans inquired of the insurance department. However, none were willing to be subject to all state insurance laws, so the state's process remains solely for enrollees of fully-insured plans and the state employee plan.

The process similar to the NAIC Model Act that self-insured plans may follow is comparable to Connecticut's state process, since both adhere to the NAIC Model Act. The only major difference is that the state insurance department is not involved when a self-insured plan opts to engage in its own process.

Process. The process for filing and completing an external appeal under Connecticut and federal law is described below, with differences between Connecticut's process (applying to fully-insured plans) and the process for self-insured plans (governed only by federal law) noted. Connecticut has had a CID-administered external review process, relying on independent review organizations, for its fully-insured plans since it was required by Public Act 97-99, as part of the managed care reform legislation.

1. Request made: An enrollee can file an external appeal request if no more than 120 days have passed since the most recent adverse determination was received.

Connecticut state process. The request package is sent to the insurance department and must include:

- the insurance department's prescribed form, completed;
- a copy of the enrollee's insurance card;
- the final (or, for expedited reviews, most recent) denial letter from the carrier;
- a physician certification form, if the request is for an expedited review or involves a denial based on experimental or investigational treatment;

- any new relevant medical information, if desired; and
- a \$25 filing fee³⁵ - or a request for the fee waiver - although the fee is refunded if the appeal request is accepted and the determination is reversed in whole or part.³⁶

If the application is incomplete, and the timeframe for filing an external review request has not expired, CID sends a letter to the enrollee, requesting the missing materials are sent within ten days (or within the filing timeframe, if that deadline is approaching). If the application remains incomplete at that point, CID gives the request to the carrier. The carrier declines to accept the request for eligibility review (see below), but notifies the enrollee that the missing information may still be submitted up to the filing deadline.

Self-insured plan process. An enrollee applies for review directly to the plan, without a fee. The plan may determine what forms are necessary.

2. Eligibility reviewed: The request's eligibility for external review is determined by the plan.

The request may be for a standard external appeal, or an expedited one. An expedited appeal request can be made if:

- the denial (either initial or from internal appeal) was on the basis that the treatment is experimental, and the enrollee's provider certifies in writing that the treatment would be significantly less effective if not promptly begun; or
- the timeframes for either the expedited internal review (if an initial denial) or the standard external review would jeopardize a person's life or ability to regain maximum function, or the person has not been discharged from a facility after receiving emergency services.³⁷

Connecticut state process. The insurance department must send a copy of the appeal request to the carrier, which then determines if the request is eligible for external appeal. Prior to P.A. 11-58, this function was handled by CID, except for external review applications for denials based on contractual terms, whose eligibility was decided by the independent review organization. The change was made to comply with the NAIC Model Act.

The eligibility decision must be made and conveyed to the insurance department, enrollee, and the enrollee's representative within five business days for a standard request, or a single calendar day for an expedited one.

In terms of process, the request must meet one of the following conditions:

³⁵ No individual may pay more than \$75 annually in external appeal filing fees. In other words, if four or more separate appeal requests are submitted by or on behalf of the same enrollee within a calendar year, there is no fee after the third request.

³⁶ A waiver will be granted if the enrollee's household adjusted gross income for the most recent federal tax return is less than 200 percent of the federal poverty level (e.g., \$37,060 for a family of three).

³⁷ An expedited appeal process for enrollees of Connecticut fully-insured plans was established by P.A. 09-49, though it was changed somewhat by the 2011 law.

- the internal appeals process must be exhausted;
- the carrier has agreed to waive its internal appeal process; or
- a request for an expedited internal appeal has been filed and the external review application is accompanied by a physician certification of the need for a speedy decision.

Additionally, the individual must have been covered under the plan when the service was requested (or, if there was a retrospective review determination, when the service was provided), the service must be covered under the plan, and, if the service was experimental or investigational, several additional criteria are met.³⁸

Self-insured plan process. The same timeframes and conditions apply, although the insurance department has no role.

3. Eligibility results conveyed: Within one business day of the eligibility review's completion (or, immediately, for an expedited review), the enrollee is informed of whether the request was accepted.

Connecticut state process. If the request for an expedited or standard external review is incomplete, the insurer notifies the enrollee and commissioner in writing of what information remains needed.

A determination of ineligibility must be conveyed to the enrollee and insurance department, along with the reason(s). The enrollee may appeal this decision to the commissioner, who can reverse it (i.e., accept the external appeal request).

If the request is ineligible because of plan type (e.g., not fully-insured, or Connecticut-based), the applicant is notified that the state process cannot be pursued.

Self-insured plan process. If the request is incomplete, the plan's notice must state what is needed to allow the enrollee to provide what is needed, within the longer of 48 hours or the remaining 120-day external review eligibility period. If the request is complete but ineligible, the notice must include the contact information for the federal agency that conducts enforcement in this area (U.S. Department of Labor's Employee Benefits Security Administration).

4. Case assigned to reviewer: A request that is deemed eligible for review is randomly assigned to an independent review organization. An IRO may not be associated in any way with the health plan or health care professional trade association that is the subject of the review.³⁹

Connecticut state process. The insurance department sequentially assigns the case to one of its contracted independent review organizations (IROs). The assignment occurs within one business day for a standard request that has been accepted, or one calendar day for an expedited request. By law, the IROs are paid by the carrier(s) involved in the external review on a per-

³⁸ See C.G.S. Sec. 38a-591g(e)(3)(C)

³⁹ C.G.S. Sec. 38a-591l.

review basis.⁴⁰ The per-review fee ranges from approximately \$575 to \$950 (though it may be as high as \$1,320), depending on whether the review is:

- expedited;
- about experimental or investigational treatment, and if so, whether it is in a specialty area; and/or
- involving the review of additional information, beyond what was included in the initial application package (i.e., before or after the window described in 5. below).

Currently there are five contracted IROs selected from the nine that met CID's criteria for consideration and applied through the state's competitive bidding process. The IROs must meet or exceed the standards of URAC national accreditation.⁴¹ Each IRO has between 700 and 1,000 panelists who make the external review decisions. The panelists must be either practicing or retired but on a faculty, to ensure their knowledge is up-to-date. In a particular review, the panelist selected by the IRO cannot be related to or associated with (professionally or financially) the parties, including any person, facility, or company who would benefit if coverage were given to the requested treatment.⁴²

Self-insured plan process. The plan must contract with at least three nationally accredited IROs and rotate assignments among them, with none eligible for incentives based on the likelihood of upholding the adverse determination.⁴³ The contracts must feature the timeframes and requirements that apply to the external review process.

5. Additional information shared: Once an IRO has been assigned, the enrollee has an opportunity and the carrier, an obligation, to submit relevant information. If the carrier receives additional information from the enrollee, it may decide to reverse its decision. The external review process is ended only when the carrier submits written notice of its reversal; a carrier may not stall the review process by declaring it is newly re-evaluating the request.

Connecticut state process. The enrollee has five business days, for a standard request, to submit additional information to the IRO (which then shares it with the carrier).⁴⁴ The carrier has the same five business days to share all documents and information considered, when it or its

⁴⁰ C.G.S. Sec. 38a-591g(a)(3)

⁴¹ URAC's name originally was the Utilization Review Accreditation Commission, but the name changed to simply "URAC" in 1996, when the company started to accredit other health-related organizations, beyond utilization review companies.

⁴² C.G.S. Sec. 38a-591m

⁴³ An unbiased method other than rotation may be used, but the relevant federal agencies have stated they will give close scrutiny to non-rotational assignment. Also of note: There was a period of interim safe harbor for IRO contracting. Plans were required to contract with two IROs by January 1, 2012, but at least three by July 1, 2012, per ACA regulations.

⁴⁴ The IRO may but is not required to consider information submitted after five (or, for the self-insured plan process, ten) business days, when making its decision. A carrier may choose to reconsider its adverse determination upon receipt of additional information, with no impact on the external appeal process unless and until the carrier decides to reverse its decision in full. (In such a situation, the carrier would pay a partial fee to the IRO.)

utilization review company made the adverse determination(s). If the review is expedited, only one calendar day is allowed. If the carrier decides not to share information, the IRO may reverse the decision in favor of the consumer.

Self-insured plan process. The enrollee has ten business days (not five), for a standard request, to submit additional information to the IRO. The carrier must share information as in the state process, or potentially face the same consequence.

6. Review completed: The IRO conducts the review, reviewing all documents and making the final decision. If the appeal is about a determination regarding medical necessity or experimental/investigational treatment, then a clinical peer (or more than one) selected by the IRO must lead the process.

State law and federal guidance specifies that the IRO must consider, among other documents, “the most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government” or medical associations.⁴⁵

The IRO must issue a written decision, including its rationale and references to the evidence or documentation it considered, within certain timeframes after its assignment of the case. The timeframes are shown in the table below. If the IRO overturns the adverse determination, in part or full, the plan must immediately pay the amount due.

Table E-3. External Appeal Decision Due Dates, From Time of IRO Assignment		
	<i>Standard</i>	<i>Expedited</i>
Involving experimental or investigational treatment	20 days	5 days
All others	45 days	72 hours

Source: PRI staff review of C.G.S. Sec. 38a-591g(i)(1) and U.S. Department of Labor Technical Release 2010-01.

Connecticut state process. The statutory definition of “clinical peer” is stricter for this level of review, compared to internal appeal. State law follows the NAIC Model Act, which requires the reviewer to be:

- an expert in the treatment of the condition that is the subject;
- knowledgeable about the recommended treatment through recent or current clinical experience covering a person with the same or similar condition;
- licensed;
- without a history of disciplinary actions or sanctions; and
- free (along with the IRO) from a variety of conflicts of interest.⁴⁶

⁴⁵ C.G.S. Sec. 38a-591g(h)(5); U.S. DOL August 2010 Technical Release 2010-01

⁴⁶ C.G.S. Sec. 38a-5911

Self-insured plan process. Federal guidance does not specifically address the clinical peer or reviewer requirements; however, guidance notes that unmentioned provisions of the NAIC Model Act do apply.

Legal Remedies

Enrollees in employer-provided health plans may file a federal lawsuit, after fully exhausting the appeals processes. Section 502(a) of the Employee Retirement Income Security Act (ERISA) allows participants to sue their plan for the cost of benefits denied, or to enforce rights under the plan.⁴⁷

Enrollees or beneficiaries have no avenue, under ERISA, to seek damages beyond benefit costs. For example, if a health plan denied certain coverage, and consequently an enrollee became permanently disabled, the enrollee cannot sue the plan for compensatory damages for the resulting lifetime loss of wages, under a theory of malpractice.

Some observers attribute this feature to the fact that ERISA was passed when health care was indemnity-only (with plans paying a set portion of medical costs to nearly any provider) and plans did not conduct utilization review. Consequently, the emphasis was on ensuring redress for pension and similar monetary benefits, and thus provided for federal preemption of state laws "related to" an employee benefit plan (except for any state law regulating insurance, banking, or securities). Although decades have passed – during which managed care has supplanted indemnity insurance, and the frequency of pensions has declined – this aspect of ERISA remains.

In order for a group health plan enrollee to sue for damages against a health plan, ERISA would need to be amended by Congress. The U.S. Supreme Court to date has held that, under ERISA, a health plan makes coverage decisions, not medical care treatment decisions. At least one state, Texas, attempted to make managed care organizations liable in state court for medical malpractice. It appears that law was struck down as a violation of ERISA pre-emption of state law, despite having been worded in a way that attempted to avoid the issue of pre-emption.⁴⁸

The carriers' behavioral health plan protocols reviewed by committee staff are careful to note that the plan reviewers who use the protocols are not making medical treatment decisions. Yet, utilization reviewers are required to be licensed health care practitioners, and the protocols explicitly state that they are an effort to define what the plan deems "medically necessary." Indeed, managed care arose as a way to encourage medical decisions be made in a way that would contain rising health care costs (i.e., limit care, which in some cases might not be appropriately prescribed by a provider). Despite these facts, the protocols assert and the Supreme Court has held that a plan does not make treatment decisions.

Meanwhile, a treating practitioner who neglects to provide care that a carrier would not agree to cover – perhaps fearing non-payment – may be sued for medical malpractice, if that neglect led to harm or was out of line with the prevailing medical standard of care.

⁴⁷ 29 U.S.C. Sec. 1132(a)

⁴⁸ Michael Housman, "ERISA: A Legal Shield for HMOs," *Harvard Health Policy Review Archives* Vol. 1, No. 1, Fall 2000. Accessed July 18, 2012 at: <http://www.hcs.harvard.edu/~epihc/currentissue/fall2000/housman.html>.

It could be argued that, for the large portion of the population that cannot afford to pay out of pocket, a health plan's denial for certain types of high-cost care otherwise covered under the plan forces an enrollee to choose between foregone care or financial short- or long-term catastrophe. In some circumstances, the foregone care may have proven not to have been necessary to life and good health; in others, it might have been. During the June 2012 public hearing on this study, several parents testified that private insurer denials of coverage for their children's substance use treatment had driven them to desperate financial circumstances, as they chose to not forgo care.

Recent Fully-Insured Commercial Plan Utilization Review Data

The CID's annual Consumer Report Card on Consumer Report Card on Health Insurance Carriers in Connecticut contains some information on behavioral health utilization review and appeals. The data, however, have some limitations for this study. First, initial determination and appeals data are available only for "behavioral health" as an aggregate category. Therefore, it is impossible to determine substance use-specific information, or compare that to mental health data. Second, those data are insufficiently specific about level of care, for this study's purposes. The requests are categorized as inpatient admissions, outpatient services, procedures, and extensions of stay.

Due to the CID data's shortcomings, behavioral health (substance use, mental health, and co-occurring disorders separately) utilization review and appeals data for 2009, 2010, and 2011 was requested of the state's major carriers (i.e., health plans) by program review committee staff. The carriers agreed to share data for 2011 only according to primary diagnosis, for youth within fully-insured plans.⁴⁹ The data were submitted by health plan, but without identification.

External review applications and results information was provided by the Connecticut Insurance Department, and analyzed by committee staff.

In addition to these data sources, program review committee staff surveyed about half of the state's behavioral health care practitioners, using methods detailed in Appendix G. Results from the survey are interspersed below, where relevant. These results are limited to respondents (n=457) who indicated that at the time of the survey (October 2012) they were counseling at least one client with a substance use or co-occurring disorder.

Connecticut Carriers' Data

Context. The four carriers offering fully-insured HMO plans that provided enrollment data enrolled 310,816 Connecticut youth (ages 12 through 25) in 2011. This group was about 6.3 percent of the state's total population.⁵⁰ (The fifth carrier did not provide enrollment data.)

⁴⁹ A similar request was made of the Office of the Comptroller for the state employee health plan, which is self-insured. Although the office agreed and took steps to acquire the data, none were made available in time for this study's analysis.

⁵⁰ "Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 2, 2010 to July 1, 2011," Population Estimates; State Totals - Vintage 2011, United States Census Bureau, U.S. Department of Commerce. Accessed November 12, 2012 at: <http://www.census.gov/popest/data/state/totals/2011/>

Table F-1. Fully-Insured Connecticut Plan Youth Enrollment, 2011						
	<i>Ages 12-17</i>		<i>Ages 18-25</i>		<i>Ages 12-25</i>	
	<i>Number</i>	<i>% of Total</i>	<i>Number</i>	<i>% of Total</i>	<i>Total Number</i>	<i>% of Total</i>
Plan A	8,281	10%	12,626	9%	20,907	9%
Plan B	30,109	36%	64,387	45%	94,496	42%
Plan C	25,422	30%	35,838	25%	61,260	27%
Plan D	20,728	25%	28,885	20%	49,613	22%
TOTAL	84,540	100%	141,736	100%	226,276	100%
Note: One of the five health plans is omitted from the presentation and calculations above because it did not submit data.						
Source: PRI staff calculations using CT Association of Health Plans data.						

Of the four carriers represented, Plan A had the smallest market share among this age group and these types of plans, while Plan B had the largest - particularly among young adults - according to the data presented in Table F-1. Plan C's share of enrollment is second-highest.

Among these enrollees, only a very small percentage was treated at a particular level of care in 2011 for substance use, mental health, or co-occurring disorders. Table F-2 indicates that, for each level above outpatient, less than 0.3% of the plans' total enrollment received that level of care.⁵¹ There is some variation among plans within each level, but the data were not received by program review committee staff in sufficient time to undertake analysis for statistical significance or receive plan representatives' views on possible reasons for the variations.

Similarly, for each plan, a tiny share of its youth enrollment - between 0.1 and 1.7 percent - received coverage for at least one level of substance use treatment that required utilization review, as shown by Table F-3 below. (Standard outpatient therapy / counseling generally is not included, except perhaps for plans A and E.)

⁵¹ It is important to note that these data do *not* indicate the share of any plan's youth enrollment that received any type of behavioral health services in 2011. A particular enrollee may have received multiple levels of care during the year. In fact, a person who received inpatient or residential treatment is encouraged by the carrier and ideally assisted by the treating facility in arranging and, upon discharge, engaging in partial hospitalization or intensive outpatient care. Therefore, the data cannot be used to sum the number of unique individuals who received behavioral health care.

**Table F-2. Behavioral Health Treatment Received By Youth
With Fully-Insured Plan (Unique Enrollees by Level of Care), 2011**

	<i>Ages 12-17</i>		<i>Ages 18-25</i>		<i>Ages 12-25</i>	
	<i>Number</i>	<i>% Plan's Enrollment</i>	<i>Number</i>	<i>% Plan's Enrollment</i>	<i>Number</i>	<i>% Plan's Enrollment</i>
Inpatient	237	0.3%	483	0.3%	720	0.3%
Plan A	23	0.3%	28	0.2%	51	0.2%
Plan B	43	0.1%	128	0.2%	171	0.2%
Plan C	99	0.4%	189	0.5%	288	0.5%
Plan D	72	0.3%	138	0.5%	210	0.4%
Residential	16	0.0%	86	0.1%	102	0.0%
Plan A	2	0.0%	3	0.0%	5	0.0%
Plan B	11	0.0%	35	0.1%	46	0.0%
Plan C	1	0.0%	8	0.0%	9	0.0%
Plan D	2	0.0%	40	0.1%	42	0.1%
Partial Hosp.	106	0.1%	156	0.1%	262	0.1%
Plan A	9	0.1%	14	0.1%	23	0.1%
Plan B	21	0.1%	48	0.1%	69	0.1%
Plan C	41	0.2%	48	0.1%	89	0.1%
Plan D	35	0.2%	46	0.2%	81	0.2%
Intensive OP	240	0.3%	472	0.3%	712	0.3%
Plan A	17	0.2%	24	0.2%	41	0.2%
Plan B	38	0.1%	92	0.1%	130	0.1%
Plan C	71	0.3%	191	0.5%	262	0.4%
Plan D	114	0.5%	165	0.6%	279	0.6%
Outpatient*	1,895	2.2%	2,601	1.8%	4,496	2.0%
Plan A	368	4.4%	398	3.2%	766	3.7%
Plan B	25	0.1%	16	0.0%	41	0.0%
Plan C	308	1.2%	356	1.0%	664	1.1%
Plan D	1,194	5.8%	1,831	6.3%	3,025	6.1%

*Plans B and C provided outpatient utilization data only for those youth whose outpatient treatment fell under the purview of utilization review. Plan B only requires utilization review for non-routine outpatient care (e.g., services other than the standard 50-minute office visit), while Plan C's 2011 business required prior authorization after the first 12 routine visits per provider in a year.

Notes: One of the five health plans is omitted from the presentation and calculations above because it did not submit this data. This chart includes treatment for any behavioral health disorder. A person may have received treatment at a particular level of care multiple times within the year.

Source: PRI staff calculations using CT Association of Health Plans data.

Table F-3. Youth in Fully-Insured Plans Receiving Coverage For At Least One Level of Substance Use Treatment Requiring Utilization Review, 2011*						
	<i>Ages 12-17</i>		<i>Ages 18-25</i>		<i>Ages 12-25</i>	
	<i>Number</i>	<i>% Plan's Enrollment</i>	<i>Number</i>	<i>% Plan's Enrollment</i>	<i>Number</i>	<i>% Plan's Enrollment</i>
Plan A	3	0.0%	23	0.2%	26	0.1%
Plan B	7	0.0%	67	0.1%	74	0.1%
Plan C**	408	1.6%	604	1.7%	1,012	1.7%
Plan D	29	0.1%	137	0.5%	166	0.3%
Plan E	60	unknown	106	unknown	166	unknown

*For Plan E, not all intensive outpatient or outpatient care underwent utilization review; employers can choose whether to require authorization for those services.
**Plan C submitted data that appears to include all youth enrollees who received substance use treatment, regardless of whether utilization review was required.
Notes: "Substance use treatment" is based on a person with a primary substance use disorder diagnosis having received coverage for at least one type of behavioral health care that required utilization review. Plan E did not share data on its youth enrollment.
Source: PRI staff calculations using CT Association of Health Plans data.

Initial determinations. The insurer data were analyzed by level of care and timing of utilization review for each plan. Outpatient treatment was excluded because of differences among (and within) the plans regarding whether utilization review was required for certain services.

There is one large caveat to keep in mind when reviewing the analysis below. Situations in which an insurer agreed to cover a given level of care but for fewer days (before a concurrent review) than initially requested by a practitioner were treated as an "approval." Program review committee staff had asked for separate data on these partial authorizations but was informed that none were available (although Plan E data indicated a few were given). One smaller problem is that appeals data are estimates. This is because the number of appeals was given by year, so some 2011 appeals may have resulted from requests made in 2010, while some 2011 requests might not have been appealed until 2012.

All determinations for substance use treatment. Across all utilization review timings, the data as presented in Table F-4 indicate the overall approval rate (the third numerical column) was 88 percent.

The approval rate varies between levels of care and, within any given level, among health plans. For example, the approval rate for inpatient care is 89 percent, while for residential treatment it was 73 percent. Within even partial hospitalization care, which had the highest approval rate of the three highest-level services, the initial approval rate ranged from Plan B's 99 percent to Plan A's (with a very small number of requests) 71 percent. There was the least variation in approval rates for intensive outpatient.

**Table F-4. All Coverage Requests, Approvals, and Appeals of Denials
by Level of Care Requested, for Fully-Insured Plan Youth 12-25
With a Primary Substance Use Diagnosis, 2011**

	<i># Requests</i>	<i># Approved</i>	<i>% Approved</i>	<i># Appealed</i>	<i>Est. % Denials Appealed</i>
Inpatient (all)	412	368	89%	20	45%
Plan A	14	10	71%	2	50%
Plan B	117	114	97%	0	0%
Plan C	85	57	67%	11	39%
Plan D	84	79	94%	4	80%
Plan E	112	108	96%	3	75%
Residential (all)	332	243	73%	33	37%
Plan A	22	12	55%	3	30%
Plan B	126	115	91%	2	18%
Plan C	62	7	11%	27	49%
Plan D	84	76	90%	1	13%
Plan E	38	33	87%	0	0%
Partial Hosp. (all)	194	180	93%	2	14%
Plan A	7	5	71%	0	0%
Plan B	81	80	99%	0	0%
Plan C	32	29	91%	1	33%
Plan D	44	39	89%	0	0%
Plan E	30	27	90%	1	33%
Intensive OP (all)	339	332	98%	9	*
Plan A	21	21	100%	---	---
Plan B	0	---	---	---	---
Plan C	124	118	95%	9	*
Plan D	147	147	100%	---	---
Plan E	47	46	98%	0	0
TOTAL (all)	1,277	1,123	88%	64	42%
Plan A	64	48	75%	5	31%
Plan B	324	309	95%	2	13%
Plan C	303	211	70%	48	52%
Plan D	359	341	95%	5	28%
Plan E	227	214	94%	4	31%

*Plan C's Intensive outpatient data indicated a greater number of appeals than denials because the denials and appeals were pulled from the data system separately, by year (instead of attached to 2011 requests). Therefore, the percent of denials appealed appears nonsensical and therefore is omitted here, with a note that consequently Plan C's total percent of denials appealed is strongly influenced by this characteristic.

Source: PRI staff calculations using CT Association of Health Plans data.

The data additionally indicate that, of these levels of care, approval for residential substance use treatment coverage is the most difficult to obtain, with a 73 percent approval rate (for requested, ongoing, or received care) when the five plans' data are combined. This is consistent with the information gathered from the study's June public hearing and committee staff's interviews.

Further, the variation among plan approval rates is even more pronounced, for residential care. Plan B's highest rate of 91 percent was about eight times higher than the lowest rate, Plan C's 11 percent. The next-largest high-low spread for the three highest levels of care was 30 percentage points for inpatient care.

Concurrent determinations for substance use treatment. The insurer data were analyzed by the timing of utilization review: prospective, concurrent, and retrospective. Special attention was paid to concurrent review because of public hearing testimony and interviewee assertions that these requests - which are made to extend the covered stay - often are denied. The data show in Table F-5 that while there is some variation among plans within a given level of care, and across levels of care when plan data are combined, about 11 of every 12 requests for coverage or extension of treatment already in progress were approved. It is important to remember that an approval can include a request that was granted but for a shorter length of stay or number of visits.

Comparison of initial coverage approval rates for substance use and mental health diagnoses. The insurer data were analyzed to determine if there may be a difference in the coverage approval rate (the result of the first determination), between treatment for a substance use disorder and that for a mental health disorder. For this analysis, all determinations - prospective, concurrent, and retrospective - were included.

The data (shown in Table F-6) indicate that the coverage approval rates for two of the three high levels of care were slightly lower for substance use disorder treatment than for mental health treatment. The difference in the rates was four and five percentage points for inpatient and partial hospitalization care, respectively. For residential treatment, however, the initial approval rate was markedly lower for those with a substance use diagnosis, at 73 percent compared to 84 percent for mental health treatment.

Table F-5. Concurrent Review Coverage Requests, Approvals, and Appeals of Denials by Level of Care Requested, for Fully-Insured Plan Youth 12-25 With a Primary Substance Use Diagnosis, 2011

	<i># Requests</i>	<i># Approved</i>	<i>% Approved</i>	<i># Appealed</i>	<i>Est. % Denials Appealed</i>
Inpatient (all)	225	213	95%	8	67%
Plan A	10	10	100%	---	---
Plan B	40	40	100%	---	---
Plan C	10	5	50%	1	50%
Plan D	83	78	94%	4	80%
Plan E	82	80	98%	3*	100%
Residential (all)	200	176	88%	4	17%
Plan A	14	8	57%	1	17%
Plan B	71	66	93%	1	20%
Plan C	1	0	0%	1	100%
Plan D	82	75	91%	1	14%
Plan E	32	27	84%	0	0%
Partial Hosp. (all)	92	82	89%	2	20%
Plan A	7	5	71%	0	0%
Plan B	36	36	100%	---	---
Plan C	1	0	0%	1	100%
Plan D	23	18	78%	0	0%
Plan E	25	23	92%	1	50%
Intensive OP (all)	136	130	96%	4	67%
Plan A	15	15	100%	---	---
Plan B	0	---	---	---	---
Plan C	11	6	55%	4	80%
Plan D	85	85	100%	---	---
Plan E	25	24	96%	0	0%
TOTAL (all)	653	601	92%	18	35%
Plan A	46	38	83%	1	13%
Plan B	147	142	97%	1	20%
Plan C	23	11	48%	7	58%
Plan D	273	256	94%	5	29%
Plan E	164	154	94%	4	40%

Notes: Plan D's concurrent review data for residential treatment appears to indicate that the plan considered nearly all residential treatment requests as involving "concurrent review," so it seems that many of these requests were for initial authorization (not extension of stay).

*Plan E's number of appeals, 3, is greater than its number of requests denied, likely because denials and appeals were pulled from the data system separately, by year (instead of attached to 2011 requests).

Source: PRI staff calculations using CT Association of Health Plans data.

Table F-6. All Coverage Requests, Approvals, and Appeals of Denials by Level of Care Requested and Primary Diagnosis, for Fully-Insured Plan Youth 12-25, 2011					
	<i># Requests</i>	<i># Approved</i>	<i>% Approved</i>	<i># Appealed</i>	<i>Est. % Denials Appealed</i>
Inpatient (all)	2,233	2,054	92%	101	56%
Substance use	412	368	89%	20	45%
Mental health	1,821	1,686	93%	81	60%
Residential (all)	572	445	78%	53	42%
Substance use	332	243	73%	33	37%
Mental health	240	202	84%	20	53%
Partial Hosp. (all)	643	618	96%	5	20%
Substance use	194	180	93%	2	14%
Mental health	449	438	98%	3	27%
Intensive OP (all)	1,120	1,096	98%	14	58%
Substance use	339	332	98%	9	129%*
Mental health	781	764	98%	5	29%
TOTAL (all)	4,568	4,213	92%	173	49%
Substance use	1,277	1,123	88%	64	42%
Mental health	3,291	3,090	94%	109	54%

Note: This is possible because, for at least some plans, denials and appeals were pulled from the data system separately, by year (instead of attached to 2011 requests).
Source: PRI staff calculations using CT Association of Health Plans data.

Internal appeals requested. The data (as presented in the tables above) show that about half of all behavioral health denials are appealed, but somewhat less (42 percent) for substance use care. For the three high levels of substance use care, no plan consistently had high appeals rates.

When prospective, concurrent, and retrospective data for substance use treatment appeals are examined separately, some interesting differences are illuminated. The appeals rate for prospective review denials of coverage approached 50 percent for both inpatient care and residential treatment. (All partial hospitalization prospective requests were approved, so there was no appeals rate.) The same rate for concurrent review denials was 67 percent for inpatient care, but was approximately 20 percent for residential treatment as well as for partial hospitalization. Finally, only two of the 16 retrospective coverage denials (13 percent) issued across levels of care was appealed. (Retrospective denials indicate that the plan declined to pay for care already given.)

Table F-7. Prospective Review Coverage Requests, Approvals, and Appeals of Denials by Level of Care Requested, for Fully-Insured Plan Youth 12-25 With a Primary Substance Use Diagnosis, 2011

	<i># Requests</i>	<i># Approved</i>	<i>% Approved</i>	<i># Appealed</i>	<i>Est. % Denials Appealed</i>
Inpatient (all)	161	133	83%	12	43%
Plan A	4	0	0%	2	50%
Plan B	56	55	98%	0	0%
Plan C	70	49	70%	10	48%
Plan D	1	1	100%	---	---
Plan E	30	28	93%	0	0%
Residential (all)	106	49	46%	28	49%
Plan A	7	4	57%	1	33%
Plan B	35	33	94%	1	50%
Plan C	57	6	11%	26	51%
Plan D	1	0	0%	0	0%
Plan E	6	6	100%	---	---
Partial Hosp. (all)	93	92	99%	0	0%
Plan A	0	---	---	---	---
Plan B	38	38	100%	---	---
Plan C	29	29	100%	---	---
Plan D	21	21	100%	---	---
Plan E	5	4	80%	0	0%
Intensive OP (all)	184	184	100%	4*	---
Plan A	5	5	100%	---	---
Plan B	0	---	---	---	---
Plan C	103	103	100%	4*	---
Plan D	54	54	100%	---	---
Plan E	22	22	100%	---	---
TOTAL (all)	544	458	84%	44	51%
Plan A	16	9	56%	3	43%
Plan B	129	126	98%	1	33%
Plan C	259	187	72%	40	56%
Plan D	77	76	99%	0	0%
Plan E	63	60	95%	0	0%

*Plan C's Intensive outpatient data indicated a greater number of appeals than denials because the denials and appeals were pulled from the data system separately, by year (instead of attached to 2011 requests). Therefore, the percent of denials appealed appears nonsensical and therefore is omitted here, with a note that consequently Plan C's total percent of denials appealed is strongly influenced by this characteristic.

Source: PRI staff calculations using CT Association of Health Plans data.

Table F-8. Retrospective Review Coverage Requests, Approvals, and Appeals of Denials by Level of Care Requested, for Fully-Insured Plan Youth 12-25 With a Primary Substance Use Diagnosis, 2011					
	<i># Requests</i>	<i># Approved</i>	<i>% Approved</i>	<i># Appealed</i>	<i>Est. % Denials Appealed</i>
Inpatient (all)	26	22	85%	0	0%
Plan A	0	---	---	---	---
Plan B	21	19	90%	0	0%
Plan C	5	3	60%	0	0%
Plan D	0	---	---	---	---
Plan E	0	---	---	---	---
Residential (all)	26	18	69%	1	13%
Plan A	1	0	0%	1	100%
Plan B	20	16	80%	0	0%
Plan C	4	1	25%	0	0%
Plan D	1	1	100%	--	--
Plan E	0	---	---	---	---
Partial Hosp. (all)	9	6	67%	0	0%
Plan A	0	---	---	---	---
Plan B	7	6	86%	0	0%
Plan C	2	0	0%	0	0%
Plan D	0	---	---	---	---
Plan E	0	---	---	---	---
Intensive OP (all)	19	18	95%	1	100%
Plan A	1	1	100%	---	---
Plan B	0	---	---	---	---
Plan C	10	9	90%	1	100%
Plan D	8	8	100%	---	---
Plan E	0	---	---	---	---
TOTAL (all)	80	64	80%	2	13%
Plan A	2	1	50%	1	100%
Plan B	48	41	85%	0	0%
Plan C	21	13	62%	1	13%
Plan D	9	9	100%	0	---
Plan E	0	---	---	---	---

Source: PRI staff calculations using CT Association of Health Plans data.

Internal and external appeals results. The tables below show that the rates of success (from the enrollee's perspective) for internal and external appeals (i.e., external review) were

low. When all levels of care above outpatient, types of behavioral health care, and timings of utilization review are considered, the internal appeals success rate was 11 percent and the external rate, 19 percent, according to Table F-9. There was some variation across the levels of care and timings, but no level's internal appeals overturn rate was above 27 percent (when there were more than two appeals), which was the rate for residential rehabilitation concurrent reviews.

Substance use treatment requests had an internal success rate one-third of mental health treatment requests, but a higher external success rate (though the numbers are small). Relatively few retrospective review denials were appealed, and the success rate at both the internal and external levels was zero (with only one such external appeal).

Plan differences. The plans' substance use treatment appeals information is compared in Table F-13. Among only substance use treatment requests, Plan C had, by far, the highest number of appeals - 49, compared to a total of 16 for all the other (four) plans. No other plan had more than five internal appeals for substance use care. Plan C's internal appeals success rate was very low, at four percent, but on the other hand, its external appeals success rate of 25 percent (with only four external reviews) was not high compared to the overall CID external review success rate.

The majority (55 percent) of Plan C appeals were for residential care; all but one of the residential care appeals were of prospective review (i.e., pre-admission) decisions. Plan C also had most (54 percent) of all the plans' residential care prospective requests and, for these, a very low approval rate (11 percent - compared to 88 percent among the other plans), as shown by Table F-7.⁵²

Meaning. With these data, it is not advisable to draw conclusions about the reasons for the low success rates. There are a number of possible explanations, particularly for internal appeals. For example, perhaps the first determinations frequently were consistent in the way they applied the plan's protocols, or maybe enrollees or providers often do not submit new information.

Whatever the cause, the low internal appeals success rate could lead one to question the value of the internal appeal step. Only 11.5 percent of denials that were unsuccessfully appealed to the plan were pursued by enrollees to the external review process. (A small portion of denials may have been due to exhausted benefits and other non-medical necessity reasons, but it is likely the vast majority were not.) If the existence of the external review process is intended to, among other things, motivate plans to make the correct or reasonable decision during the initial determination or internal appeal, it likely is failing in that respect because a very small share of denied enrollees progress all the way through the appeals processes.

The program review committee did not make a recommendation about the existence of the internal appeal - or the presence of a second level in group plans - for two reasons. First, it often is conducted much more quickly than is feasible for an external appeal. Second, the internal appeal process is widely accepted and allowed under federal law.

⁵² As noted above, at least a portion of Plan D concurrent review requests for residential substance use treatment must have been the plan's first review of the request (i.e., might more appropriately be considered prospective requests). That could change Plan C's designation of having the highest number of residential treatment requests, but likely not its status as the plan with the lowest approval rate for that type of request. Table F-5 shows that Plan D's approval rate for concurrent review of residential substance use treatment requests was 91 percent.

Table F-9. Internal and External Appeals Results by Level of Care Requested and Primary Diagnosis, for Fully-Insured Plan Youth 12-25, 2011						
	<i>Internal Appeals</i>			<i>External Appeals</i>		
	<i># Appeals</i>	<i># Successful</i>	<i>% Successful</i>	<i># Appeals</i>	<i># Successful</i>	<i>% Successful</i>
Inpatient (all)	101	12	12%	7	1	14%
Substance use	20	1	5%	0	0	---
Mental health	81	11	14%	7	1	14%
Residential (all)	53	5	9%	8	2	25%
Substance use	33	1	3%	4	2	50%
Mental health	20	4	20%	4	0	0%
Partial Hosp. (all)	6	1	17%	1	0	0%
Substance use	3	0	0%	1	0	0%
Mental health	3	1	33%	0	0	---
Intensive OP (all)	14	1	7%	0	0	---
Substance use	9	1	11%	0	0	---
Mental health	5	0	0%	0	0	---
TOTAL (all)	174	19	11%	16	3	19%
Substance use	65	3	5%	5	2	40%
Mental health	109	16	15%	11	1	9%

Source: PRI staff calculations using CT Association of Health Plans data.

Table F-10. Internal and External Appeals Results of Prospective Utilization Review Denials, by Level of Care Requested and Primary Diagnosis, for Fully-Insured Plan Youth 12-25, 2011						
	<i>Internal Appeals</i>			<i>External Appeals</i>		
	<i># Appeals</i>	<i># Successful</i>	<i>% Successful</i>	<i># Appeals</i>	<i># Successful</i>	<i>% Successful</i>
Inpatient (all)	14	2	14%	0	---	---
Substance use	12	0	0%	0	---	---
Mental health	2	2	100%	---	---	---
Residential (all)	38	2	5%	6	1	17%
Substance use	28	1	4%	3	1	33%
Mental health	10	1	10%	3	0	0
Partial Hosp. (all)	2	1	50%	0	---	---
Substance use	1	0	0%	0	---	---
Mental health	1	1	100%	---	---	---
Intensive OP (all)	4	0	0%	0	---	---
Substance use	4	0	0%	0	---	---
Mental health	0	---	---	---	---	---
TOTAL (all)	58	5	9%	6	1	17%
Substance use	45	1	4%	3	1	33%
Mental health	13	4	31%	3	0	0%

Source: PRI staff calculations using CT Association of Health Plans data.

Table F-11. Internal and External Appeals Results of Concurrent Utilization Review Denials, by Level of Care Requested and Primary Diagnosis, for Fully-Insured Plan Youth 12-25, 2011

	<i>Internal Appeals</i>			<i>External Appeals</i>		
	<i># Appeals</i>	<i># Successful</i>	<i>% Successful</i>	<i># Appeals</i>	<i># Successful</i>	<i>% Successful</i>
Inpatient (all)	79	10	13%	6	1	17%
Substance use	8	1	13%	0	---	---
Mental health	71	9	13%	6	1	17%
Residential (all)	11	3	27%	2	1	50%
Substance use	4	0	0%	1	1	100%
Mental health	7	3	43%	1	0	0%
Partial Hosp. (all)	4	0	0%	1	0	0%
Substance use	2	0	0%	1	0	0%
Mental health	2	0	0%	0	---	---
Intensive OP (all)	7	1	14%	0	---	---
Substance use	4	1	25%	0	---	---
Mental health	3	0	0%	0	---	---
TOTAL (all)	101	14	14%	9	2	22%
Substance use	18	2	11%	2	1	50%
Mental health	83	12	14%	7	1	14%

Source: PRI staff calculations using CT Association of Health Plans data.

Table F-12. Internal and External Appeals Results of Retrospective Utilization Review Denials, by Level of Care Requested and Primary Diagnosis, for Fully-Insured Plan Youth 12-25, 2011

	<i>Internal Appeals</i>			<i>External Appeals</i>		
	<i># Appeals</i>	<i># Successful</i>	<i>% Successful</i>	<i># Appeals</i>	<i># Successful</i>	<i>% Successful</i>
Inpatient (all)	8	0	0%	1	0	0%
Substance use	0	---	---	---	---	---
Mental health	8	0	0%	1	0	0%
Residential (all)	4	0	0%	0	---	---
Substance use	1	0	0%	0	---	---
Mental health	3	0	0%	0	---	---
Partial Hosp. (all)	0	---	---	---	---	---
Intensive OP (all)	3	0	0%	0	---	---
Substance use	1	0	0%	0	---	---
Mental health	2	0	0%	0	---	---
TOTAL (all)	15	0	0%	1	0	0%
Substance use	2	0	0%	0	---	---
Mental health	13	0	0%	1	0	0%

Source: PRI staff calculations using CT Association of Health Plans data.

Table F-13. Internal and External Appeals Results by Level of Care Requested and Plan, for Fully-Insured Plan Youth 12-25 with a Primary Substance Use Diagnosis, 2011

	<i>Internal Appeals</i>			<i>External Appeals</i>		
	<i># Appeals</i>	<i># Successful</i>	<i>% Successful</i>	<i># Appeals</i>	<i># Successful</i>	<i>% Successful</i>
Inpatient (all)	20	1	5%	0	---	---
Plan A	2	0	0%	0	---	---
Plan C	11	0	0%	0	---	---
Plan D	4	1	25%	0	---	---
Plan E	3	0	0%	0	---	---
Residential (all)	33	1	3%	4	2	50%
Plan A	3	0	0%	1	1	100%
Plan B	2	0	0%	0	0	0%
Plan C	27	1	4%	3	1	33%
Plan D	1	0	0%	0	---	---
Partial Hosp. (all)	3	0	0%	1	0	0%
Plan C	2	0	0%	1	0	0%
Plan E	1	0	0%	0	---	---
Intensive OP (all)	9	1	11%	0	---	---
Plan C	9	1	11%	0	---	---
TOTAL (all)	65	3	5%	5	2	40%
Plan A	5	0	0%	1	1	100%
Plan B	2	0	0%	0	---	---
Plan C	49	2	4%	4	1	25%
Plan D	5	1	20%	0	---	---
Plan E	4	0	0%	0	---	---

Note: Those plans that had no appeals for a given level are not shown.
 Source: PRI staff calculations using CT Association of Health Plans data.

Survey Data

Internal appeals requested. About one quarter (23 percent) of survey respondents had appealed or helped a client do so, within the last year.⁵³ These appeals participants also estimated the number of times they had done so and the percent of denials they had appealed, during the same timeframe. The median number of appeals was four, while the median percent of denials appealed was quite low: 10%.⁵⁴

⁵³ Excluding the 90 respondents whose employer(s) does not accept private insurance, but including two respondents with the same condition who indicated they had filed one of these appeals. There were 334 relevant respondents to this question.

⁵⁴ Sixty-five respondents provided an estimate of the number of times they had filed or helped with an appeal in the last year - 84 percent of the 77 who indicated they had done so at least once.

Appeals Perceptions

There appear to be a few reasons why a large portion of denials are not appealed. First, interviews with advocates and some testimony during the study's June 2012 public hearing indicated that enrollees who have received denials often are discouraged and overwhelmed. They may be unsure of how to proceed and doubtful of their ability to successfully challenge a large carrier's decision. The data indicate, however, that appeals can and occasionally do result in overturned decisions. This is particularly true when the healthcare advocate's office provides assistance. The advocate's office states that its success rate for the consumer (involving all types of health care coverage requests) is 85 percent.

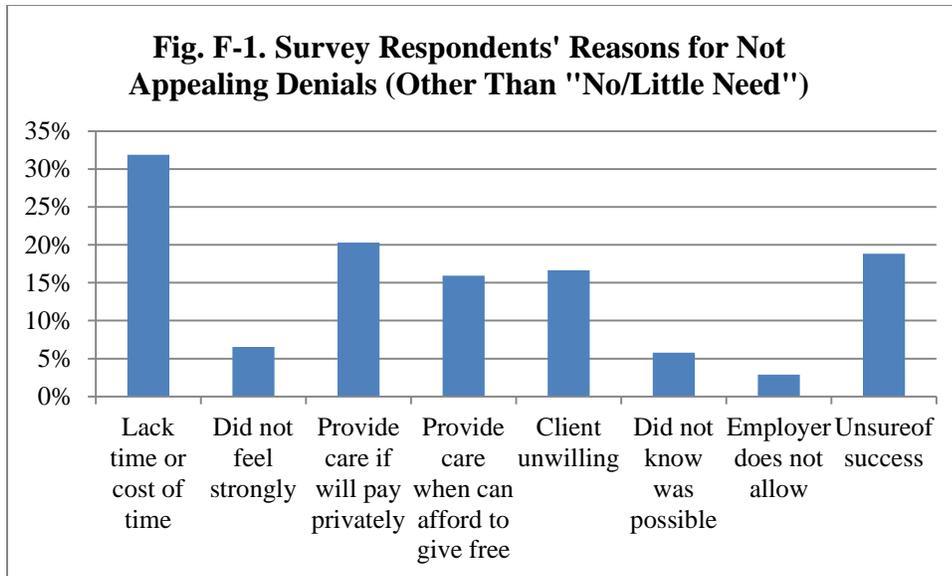
Second, CID and carrier staff noted that some enrollees are reluctant to request providers submit more documentation, unaware of the right to make that request, or unsure of what documentation could be submitted. CID and carrier staff report that supporting documentation is very helpful and many times leads to a reversal in the consumer's favor. The statutorily-required denial notice language does not include any indication that this documentation often is helpful, specify exactly what supporting documentation would be advantageous, or note that the consumer has the right to request the providers submit more information.

Third, data from the program review committee staff survey of practitioners indicates that the unreimbursed time required for a provider to pursue and support an appeal can be a deterrent.

Fourth, it is possible that carriers are able to convey to the prescribing practitioner what treatment would be considered medically necessary, and that the practitioner and/or the enrollee accepts and is reasonably satisfied with that alternative course of action.

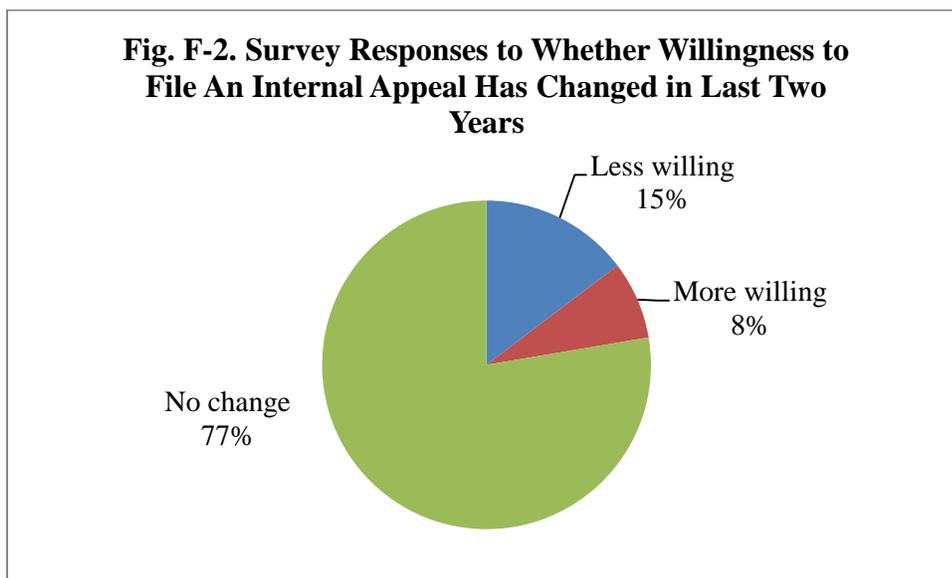
Survey data. Survey data provide some additional information and illumination, from the treating practitioner's perspective. Just under half (47 percent) of responding practitioners indicated they had not always filed an appeal because few, if any, of their requests had been turned down. Other practitioners gave a range of reasons, shown in the chart below.⁵⁵

⁵⁵ There were 262 respondents to the question: "IF you did not always file for an appeal, why not?" Respondents were allowed to select multiple options; hence, the chart percentages do not sum to 100. The chart is limited to those 138 respondents who did not select the "No need..." option.



The most common reason was the time it takes to appeal a decision. It should be noted that the survey had two separate time options - one for a lack of time given the practitioner's workload, and the other noting the work of an appeal is unpaid time - and the chart combines both. About half as many people chose the "unpaid time" option as the workload version, though people could - and some did - select both. The program review committee is unsure of how this factor could be removed, to encourage appeals, short of requiring carriers to allow providers to bill for time spent supporting and/or contesting coverage decisions.

Another survey question asked whether practitioners' willingness to file an appeal had changed within the last two years, and if it had, to describe how and why. The aim of the question was two-fold: first, to understand whether there had been any recent trends in this area, and second, to learn whether any of the ACA or Connecticut statute revisions had impacted practitioners' willingness to appeal.



More than three-quarters of survey respondents stated that their willingness to file an internal appeal to a private insurer had not changed in the last two years.⁵⁶ Nearly twice as many stated their willingness had declined, as said it had risen.

The survey requested that respondents describe in their own words why their willingness had changed, if applicable. Program review committee staff reviewed and then categorized these explanations. The resulting analysis, in Table F-14 below, shows some interesting similarities in responses between those who had become more or less willing to appeal insurer denials of coverage. For example, about one-quarter of each group cited insurer inflexibility or limitations as a contributing factor. Among respondents who were less willing now to appeal, lack of past appeals success and the time demand were cited by 40 percent or more. The top reason among those more willing to appeal was the conviction, as the treating provider, in the original request's rightness. No respondent cited state or federal law changes as a contributing factor.

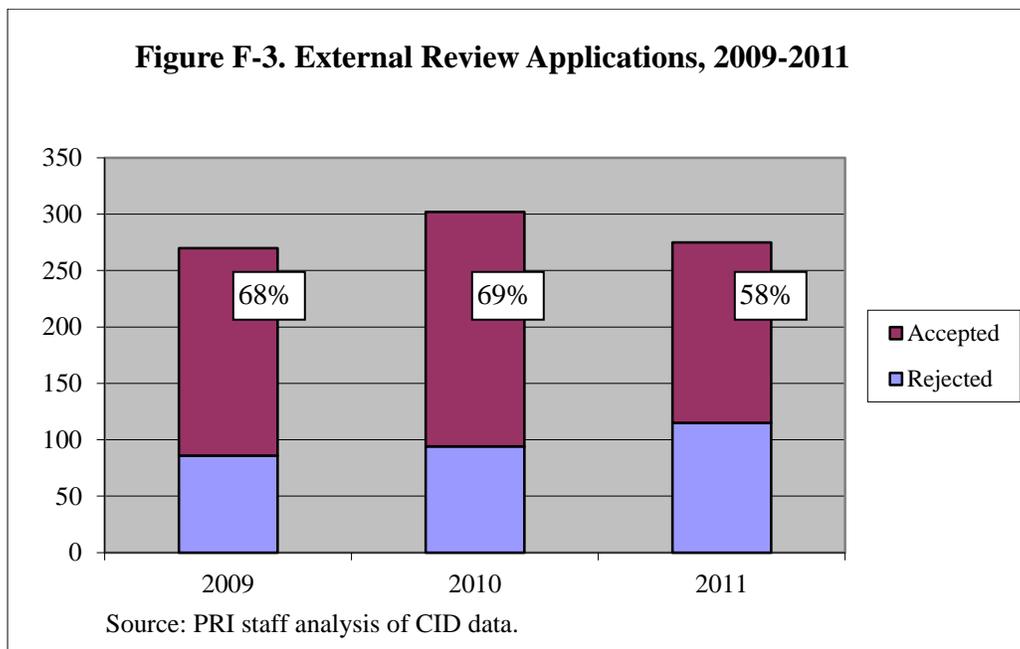
Table F-14. Reasons for Change in Willingness to File An Internal Appeal Among Survey Respondents		
	<i>Less Willing</i> n=35	<i>More Willing</i> n=16
Insurers		
Inflexible / limiting coverage	29%	25%
Make incorrect judgment / not proper judge	6%	38%
More flexibility / authorizations	0%	6%
Past appeals experiences		
Little or no success	57%	0%
Found persistence leads to success	0%	13%
Resources		
Time required to support, pursue appeal	31%	0%
Time to support, pursue appeal is unpaid	9%	0%
Change in knowledge / staff to assist in appeal	0%	19%
Notes: These responses are for those survey respondents who indicated their willingness to file an internal appeal had changed in the last two years and provided an explanation of the reasons for the change. Percentages do not sum to 100 because some individuals provided multiple reasons. Source: PRI staff analysis of practitioner survey data.		

Connecticut Insurance Department (CID) External Review (i.e., External Appeal) Data

The CID keeps records on each external appeal received and on appeals accepted for review. The insurance department provided detailed information to program review committee staff, whose data analysis is presented below.

⁵⁶ There were 233 respondents to this question.

Applications submitted. Figure F-3 shows that the insurance department annually received between 270 and 302 applications (regarding coverage for any type of health care) for external review, in each of the last three completed calendar years. The number of applications rose in 2010 but declined in 2011 to nearly its 2009 level.



The insurance department is aware that only a small portion of insurer adverse determinations are pursued through internal appeals to its external review process. Department personnel expressed to program review committee staff that CID believes the external review process is a valuable tool for consumers and a key way in preventing and ameliorating managed care abuses. Department staff stated they would like all eligible enrollees to pursue the process but are unsure how to improve enrollee participation.

Rejected applications. The insurance department has kept information on the reasons why applications are rejected since 2009, when the preliminary review process became electronic. Program review committee staff analysis of these reasons is presented in Table F-15.

The data indicate that the reasons for rejection have fluctuated substantially, despite relatively small and consistent annual growth in the number of rejections. The variation largely is due to a decline in the percent rejected because of applicant errors – especially incomplete applications – and tremendous rise in the percent rejected for procedural ineligibility. It is also interesting to note that a small but meaningful proportion of applications – around one-tenth – result in a carrier’s reversal for the consumer before the external review process was carried out.

CID noted that the shifts in percentages due to applicant errors and procedural ineligibility are likely the result of process alterations - not reflective of true changes in the types of applications received.

Table F-15. Application Rejection Reasons, 2009-2011			
	2009	2010	2011
Applicant errors	36%	57%	24%
Incomplete application	25%	45%	16%
Past filing limit	10%	13%	8%
Plan ineligible	14%	14%	15%
Sited outside CT	6%	1%	4%
Plan not eligible (federal program)	0%	3%	3%
Self-funded non-municipal plan	8%	10%	8%
Decision based on coverage/limits other than medical necessity	2%	14%	8%
Not procedurally eligible	9%	6%	42%
Withdrawn	8%	9%	11%
Unknown	31%	---	---
Total	100%	100%	100%
Notes: “Plan not eligible (federal program)” includes denials under Workers Compensation, Medicare, and Medicaid. “Decision based on coverage/limits other than medical necessity” examples are when a requested procedure is not included in the policy or coverage limitations (e.g., visit limits, procedure limits) had already been reached. “Not procedurally eligible” means that the internal appeals process has not been exhausted or waived by the carrier, the carrier did not violate the utilization review law and thus made the denial automatically eligible, or an application for expedited internal appeal has not been simultaneously requested. “Withdrawn” means, in nearly all cases 2009-2011, the carrier reversed its decision to the satisfaction of the enrollee before the external review process was carried out. Source: PRI staff analysis of CID data.			

Prior to P.A. 11-58, which made some changes to the state's utilization review and external appeals laws to make them compliant with the ACA, these applications were examined for eligibility by CID. After the public act became effective, this task shifted to the health carrier. Consequently, carrier staff began deciding why an application was ineligible. It is highly likely, then, that applications missing a final denial letter were coded by CID (before P.A. 11-58) as an incomplete application, but by carriers as not procedurally eligible.

Incomplete. There are several additional potential reasons for the decline in incomplete applications, including a revamped CID external appeal guide for consumers, which more clearly explains the process and its requirements, and a more visible and higher-staffed Office of the Healthcare Advocate. Although incomplete applications have dropped, a substantial number (18, in 2011) has continued to be received.

Procedurally ineligible. The increase in procedurally ineligible requests was attributed by insurance department staff to the fact that carriers (instead of the independent review organization) are conducting the preliminary review. As described above, it is likely that many of these requests previously were coded by CID as missing a final denial letter.

Past filing limit. One concern voiced by advocates and families to program review staff is that the filing limitation of 120 days can be especially restrictive for those seeking behavioral health coverage. Mental health and substance use disorders, they argue, are particularly disruptive to daily life. Program review committee staff heard that persons or parents (when the adolescent is the primary person seeking treatment) focus on getting into treatment and often worry about appealing a denial once the crisis has passed – often many months later.

The filing timeframe recently has been lengthened. It doubled with the 2011 public act, from 60 to 120 days. Between 2011 and 2012, there was a decline in the percent of rejections that were due to exceeding the timeframe, from 13 to 8 percent, which might have been due, at least in part, to the statute change.

A second timeframe extension could be considered, but consumer advocates believe that another extension may be counterproductive. If the timeframe is lengthened again, people may delay filing because the deadline is so far in the future - and then ultimately forget to file.

Accepted applications. The state’s external review process accepted between 160 and 208 applications annually between 2009 and 2011, as shown in the table below.

Table F-16. CID External Review Accepted Cases: Percent and Number by Type of Care Requested, 2009-2011							
	<i>2009</i>		<i>2010</i>		<i>2011</i>		<i>Total, 2009-2011</i>
All behavioral health	34%	63	43%	89	36%	57	38%
Substance use disorders	5%	9	0%	0	1%	2	2%
Co-occurring disorders	10%	19	14%	30	16%	25	13%
Mental health disorders	19%	35	28%	59	19%	30	22%
All physical health	66%	121	57%	119	64%	103	62%
Total	100%	184	100%	208	100%	160	100%

Source: PRI staff analysis of CID data.

Table F-17 shows that accepted cases involving substance use are most frequently for higher levels of care. Intensive or regular outpatient together accounted for no more than 17 percent of accepted cases, in any of the three years examined.

Table F-17. CID External Review Substance Use and Co-Occurring Accepted Cases: Level of Care Requested, 2009-2011							
	<i>2009</i>		<i>2010</i>		<i>2011</i>		<i>Total, 2009-2011</i>
Inpatient	7%	2	67%	20	15%	4	31%
Partial hospitalization	4%	1	---	0	7%	2	4%
Residential treatment	79%	22	17%	5	67%	18	53%
Intensive outpatient	11%	3	---	0	7%	2	6%
Outpatient	---	0	17%	5	4%	1	7%

Source: PRI staff analysis of CID data.

The particular levels of care, though, vary substantially among years. For example, residential treatment accounted for above two-thirds of cases in 2009 and 2011, but less than one-fifth in 2010 – a year in which most cases involved inpatient treatment.

Review results. Across types of care, external review decisions were in favor of the enrollee between 31 and 40 percent of the time, annually, between 2009 and 2011. Decisions that favor the enrollee are considered to be both complete reversals and denial revisions. An example of a revision is when the external reviewer decides a denial of a request for seven days of residential treatment should have been an approval for three days of that treatment type.

Table F-18. CID External Review Decisions: Percent in Favor of Enrollee (Reversed or Revised) by Type of Care Requested, 2009-2011				
	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>Total, 2009-2011</i>
Substance use disorders	44	---	50	45
Child	---	---	---	---
Adult	44	---	50	45
Co-occurring disorders	42	30	28	32
Child	33	50	25	36
Adult	46	27	29	32
Mental health disorders	49	39	43	43
Child	45	23	31	33
Adult	54	49	53	51
Substance use + co-occurring disorders	43	30	30	34
All behavioral health disorders	46	36	37	39
Physical (medical/surgical)	37	40	28	36
Total (all behavioral health + physical)	40	38	31	37
Source: PRI staff analysis of CID data.				

Enrollee age. Decisions on children’s behavioral health requests were reversed for the enrollee at a lower rate compared to adults, within each behavioral health category for every year, with one exception (2010 co-occurring disorders).

Type of diagnosis. Few external reviews – just eleven across the three years examined – involved substance use alone. The overturn rate for these cases was high, at 44 to 50 percent annually. The rate, however, was not statistically significantly different from those for other types of care, when three-year cumulative figures were examined.

Cases involving a substance use diagnosis (alone or co-occurring) had an overturn rate slightly or somewhat lower than that for mental health disorders not involving substance use, when adult and child data are combined. This difference was not statistically significant.⁵⁷

There does not appear to be consistency, on an annual basis, in whether behavioral health or physical health (medical/surgical) cases are reversed for the consumer more frequently. In 2009 and 2011, behavioral health decisions were in favor of the consumer at a rate nine percentage points higher than those for medical/surgical care, but in 2010, the medical/surgical consumer decision rate was higher than the behavioral health rate by four percentage points. None of these differences (annually or across the three years examined) was statistically significant.⁵⁸

Level of substance use care. Similarly, no clear pattern emerges when decisions for substance use-involving diagnoses (including co-occurring disorders) are examined by level of care, for each year, as shown in the table below. For example, the majority of 2009 and 2011 reviews involved residential treatment. In the former year, half the decisions were for the enrollee, but in the latter, less than one-quarter were. Overall, the three highest levels of care each had its highest reversal/revision rate in its peak year of reviews, but that was not the case for intensive and regular outpatient. Across the three years examined, each level of care's average overturn rate was between 31 and 40 percent.

Table F-19. CID External Review Decisions on Substance Use and Co-Occurring Accepted Cases: Percent in Favor of Enrollee (Reversed or Revised) by Level of Care Requested, 2009-2011

	2009		2010		2011		Total, 2009-2011	
	# of E.R.s	% for Enroll.	# of E.R.s	% for Enroll.	# of E.R.s	% for Enroll.	# of E.R.s	% for Enroll.
Inpatient	2	0%	20	35%	4	25%	26	31
Partial hospitalization	1	0%	0	---	2	50%	3	33
Residential treatment	22	50%	5	20%	18	22%	45	36
Intensive outpatient	3	33%	0	---	2	50%	5	40
Outpatient	0	--	5	20%	1	100%	6	33
Total	28	43%	30	30%	27	30%	85	34

Source: PRI staff analysis of CID data.

⁵⁷ The year with the biggest gap – 2011, at 13 percentage points – had a p-value of 0.28, well outside the commonly accepted threshold of p<0.05.

⁵⁸ There was a nine percentage point difference in both 2009 and 2011; the p-values were 0.25 and 0.22, respectively. The three-year cumulative percentage point difference of three percentage points had a p-value of 0.37.

Practitioner and Health Plan Level of Care Decisions

REVIEW OF FIELD'S GUIDELINES AND HEALTH PLAN CRITERIA

Clinicians, insurer medical directors, and state agency personnel with whom program review committee staff spoke agreed that that American Society for Addiction Medicine Patient Placement Criteria, Second Edition-Revised (ASAM PPC-2R) is the authoritative and most comprehensive source used by practitioners to make client level of care decisions. The Department of Mental Health and Addiction Services' client placement criteria are based on the ASAM PPC-2R, and the Behavioral Health Partnership's administrative services organization, ValueOptions, uses the ASAM PPC-2 as its substance use protocol (i.e., criteria) - as does one of Connecticut's carriers of fully-insured plans.

In addition to this general consensus on the ASAM manual as the authoritative placement source, committee staff observed that one of the state's carriers was, in 2011, issuing mental health and substance use coverage denial letters stating that their criteria were based on the ASAM manual and two additional sets of professional society recommendations. (The company's 2012 protocol still cited all three sources, in its reference list.)

These additional professional society-issued documents are the American Psychiatric Association's (APA's) Practice Guideline for the Treatment of Patients with Substance Use Disorders, Second Edition (2006), which applies to adults, and the American Academy of Child and Adolescent Psychiatry's (AACAP's) Practice Parameter for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders (2005). These guidelines can be useful but are less comprehensive (individually or together) than the ASAM manual.

The three authoritative sources on substance use disorder treatment are relatively old. None is within the five-year standard for current practice guidelines referenced by HHS's Agency for Healthcare Research and Quality. (It should be noted that the ASAM manual and child psychiatry parameters are actively being revised, according to their respective websites.)

At the same time, the research or clinical consensus regarding patient placement for substance use or co-occurring disorders does not appear to have changed substantially in recent years, based on program review committee staff conversations with practitioners, insurer medical directors, and state agency staff. (There have been some new in-home treatment models developed - such as those offered by the Behavioral Health Partnership - but these are not yet covered by Connecticut fully-insured commercial plans.) Similarly, although insurers say they update their criteria annually or more often, it is not clear their mental health and substance use disorder protocols are based on more recent research, compared to the ASAM manual or the guidelines. One of the two health plan's criteria lists references, and its enumeration includes nothing more recent than 2004.

ASAM Manual Background

The most recent version of the manual was issued in 2001. The manual's steering committee involved representatives of national professional associations, addiction researchers, state agency staff, and insurer personnel.

The ASAM manual defines, based on clinical consensus, when each level of substance use treatment might be the most appropriate, as well as what care at each level should be. A patient's situation and illness is described on six dimensions (i.e., factors), for each level. The clinician then is to locate the level of treatment based on the accompanying description of the patient. There is no checklist or strict set of criteria (although a draft proposal is in the manual's appendix); the manual notes that the patient should be in the least restrictive setting possible, but matched to the level of care appropriate to the most severe dimension.

The ASAM manual criteria are different for adolescents and adults because, as the manual explains, adolescents' developmental stage requires certain considerations. The manual states that "adolescent" applies to those 13 through 18, noting that it also frequently applies to young adults 18 to 21, who may "be in need of adolescent-type services rather than adult-type services."

Residential Treatment

Study public hearing testimony as well as committee staff interviews indicated that being able to get coverage approval of a stay in a residential treatment center is a particular concern among families and advocates. This concern extended to mental health conditions beyond substance use disorders, but staff consideration was limited to the latter, given this study's focus. Residential substance use treatment coverage requests also had the lowest coverage approval rates for fully-insured youth enrollees in 2011.

Comparison of insurer and ASAM criteria. Due to these concerns, committee staff compared the ASAM manual criteria for residential treatment to the Connecticut health plan protocols, to understand whether the protocols reflected clinical consensus. Committee staff obtained information on four of the five plans' criteria. The charts below include the criteria for three plans (with two plans sharing one set); as noted above, one of the plans uses the ASAM criteria by reference. The fifth plan did not submit its criteria in time for review.

Background. The two sets of insurer criteria do not vary between adolescents and adults. Consequently, both sets of ASAM PPC-2R residential clinically managed services criteria – adult (high-intensity) and adolescent (both medium- and high-intensity) – are compared below to the insurer criteria. The major difference between ASAM's adult and adolescent criteria for

Table G-1. Residential Treatment Center Criteria: ASAM Adult Criteria and Major Connecticut Plans' Criteria

<i>ASAM Dimension</i>	<i>ASAM Adult Criteria</i>	<i>Plan 1: All of the following, except as noted</i>	<i>Plans 2 and 3: Any of the following</i>
1. Alcohol intoxication and/or withdrawal potential	Minimal risk of severe withdrawal	Nature and pattern of use predicts clinically significant withdrawal; and factors that may indicate acute hospital care are not present	Experiencing withdrawal symptoms of extreme subjective severity but not compromising medical status to extent inpatient needed, AND 6.
			High risk of developing severe withdrawal symptoms which cannot be safely treated in a lower level of care
2. Biomedical conditions and complications	None or stable, or concurrent medical monitoring	Acute medical symptoms that would likely interfere with maintenance of recovery and abstinence outside 24-hr. setting; OR 3.	Continues to use, is at risk of exacerbating a serious co-occurring medical condition, and cannot be safely treated in a lower level of care
			High risk that continued use will exacerbate a[ny] co-occurring medical condition to the extent that treatment in a less restrictive level of care cannot be safely provided
3. Emotional, behavioral or cognitive conditions and complications	Demonstrates repeated inability to control impulses, <i>or</i> personality disorder requires structure to shape behavior	Acute psychiatric symptoms would interfere with: <i>[sic]</i> <ul style="list-style-type: none"> • maintenance of abstinence • recovery outside 24-hr. setting • have deteriorated from usual status; and • includes self injurious or risk taking behaviors posing serious harm to self or others and cannot be managed outside 24-hr setting. OR 2.	See 5.
	If severely and persistently mentally ill, a dual diagnosis enhanced setting is required		
	Other functional deficits require 24-hr. setting to teach	Evidence of major functional impairment in at least 2 domains (work/school, ADL, family/interpersonal, physical health)	Functioning has deteriorated to point that member cannot be safely treated in a less restrictive level (and continues to use)

Table G-1. Residential Treatment Center Criteria: ASAM Adult Criteria and Major Connecticut Plans' Criteria

<i>ASAM Dimension</i>	<i>ASAM Adult Criteria</i>	<i>Plan 1: All of the following, except as noted</i>	<i>Plans 2 and 3: Any of the following</i>
	<p>coping skills</p> <ul style="list-style-type: none"> • Marked difficulty with or opposition to treatment • If high severity in this dimension but not others, outpatient suitable 	<p><i>Has not been a past barrier to treatment success (see 5. below)</i></p>	
4. Readiness to change			
5. Relapse, continued use, or continued problem potential	<p>Patient has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences</p>	<p>Treatment attempted within past 3 mos. has not helped individual achieve abstinence and recovery for reasons other than lack of motivation, participation, or compliance with program recommendations</p>	<p>High risk of harm to self or others due to continued and severe use, prohibiting treatment from safely occurring in a less restrictive level of care</p> <p>See also 2. and 5.</p>
6. Recovery environment	<p>Dangerous and s/he lacks skills to cope outside of a highly structured 24-hr. setting</p>		<p>Lacks resources or functional support system needed to manage symptoms in a lower level of care, AND 1.</p>
<p>Notes: For the ASAM criteria, more severe or intense symptoms or conditions indicate a higher level of care than Level III.5. For the health plan criteria, the residential treatment detoxification criteria are presented above but generally, in the insurer protocols, are separate from those for general residential treatment criteria.</p> <p>Source: Program review committee staff comparison of two health plan protocols and the ASAM PPC-2R.</p>			

Table G-2. Residential Treatment Center Criteria: ASAM Adolescent Criteria and Major Connecticut Plans' Criteria

<i>ASAM Dimension</i>	<i>ASAM Adolescent Criteria - Level III.5</i>	<i>ASAM Adolescent Criteria - Level III.7</i>	<i>Plan 1</i>	<i>Plans 2 & 3: <u>Any of the following</u></i>
1. Alcohol intoxication and/or withdrawal potential	Experiencing mild to moderate withdrawal, but not needing pharmacological management or frequent medical or nursing monitoring	Experiencing moderate to severe withdrawal	Nature and pattern of use predicts clinically significant withdrawal; and factors that may indicate acute hospital care are not present	Experiencing withdrawal symptoms of extreme subjective severity but not compromising medical status to extent inpatient needed, AND 6.
				High risk of developing severe withdrawal symptoms which cannot be safely treated in a lower level of care
2. Biomedical conditions and complications	None or stable; <i>is receiving</i> concurrent medical monitoring	<i>Requires medical monitoring</i> , but not intensive treatment	Acute medical symptoms that would likely interfere with maintenance of recovery and abstinence outside 24-hr. setting; OR (3a-b)	Continues to use, is at risk of exacerbating a serious co-occurring medical condition, and cannot be safely treated in a lower level of care
				High risk that continued use will exacerbate a[ny] co-occurring medical condition to the extent that treatment in a less restrictive level of care cannot be safely provided
3. Emotional, behavioral or cognitive conditions and complications	<u>One</u> or more of the following:	<u>One</u> or more of the following:	(3a-b) Acute psychiatric symptoms would interfere with [sic]: <ul style="list-style-type: none"> • Abstinence maintenance; • Recovery outside 24-hr. 	

Table G-2. Residential Treatment Center Criteria: ASAM Adolescent Criteria and Major Connecticut Plans' Criteria

<i>ASAM Dimension</i>	<i>ASAM Adolescent Criteria - Level III.5</i>	<i>ASAM Adolescent Criteria - Level III.7</i>	<i>Plan 1</i>	<i>Plans 2 & 3: <u>Any of the following</u></i>
(a) Dangerousness/ lethality	<i>At moderate but stable risk of harm, needing 24-hr. monitoring or treatment for safety.</i>	<i>At moderate but stable risk of harm, needing 24-hr. monitoring or treatment, or secure facility, for safety.</i>	setting; <ul style="list-style-type: none"> • Represent deterioration from usual status; and • Include self-injurious or risk-taking behaviors that pose serious harm to self or others and cannot be managed outside 24-hr. setting. 	High risk of harm to self or others due to continued and severe use, prohibiting treatment from safely occurring in a less restrictive level of care
(b) Interference with addiction recovery efforts	<i>Moderate to severe</i>	<i>Severe</i>	OR 2.	
(c) Social functioning	<i>Moderate to severe impairment and cannot be managed at a less intensive level of care</i>	<i>Severe impairment and cannot be managed at a less intensive level of care</i>	Evidence of major functional impairment in at least 2 domains (work/school, ADL, family/interpersonal, physical health).	Functioning has deteriorated to point that member cannot be safely treated in a less restrictive level (and continues to use)
(d) Ability for self-care	<i>Moderate to severe difficulties with activities of daily living, requiring 24-hr. supervision and staff assistance</i>	<i>Severe difficulties with activities of daily living, requiring 24-hr. supervision and high-intensity staff assistance</i>		
(e) Course of illness	<i>History (combined with present situation) predicts destabilization without med.-intensity residential treatment</i>	<i>History (combined with present situation) predicts destabilization without high-intensity residential treatment</i>		
4. Readiness to change	<i>Minimal engagement in or opposition to treatment, or lack of recognition of current severe impairment</i>	<i>Lack of engagement associated with a biomedical, emotional or behavioral condition; or actively opposed to treatment, requiring confinement; or needs high-intensity case management to create linkages that would support outpatient treatment</i>	Has not been a past barrier to treatment success (see 5. below)	

Table G-2. Residential Treatment Center Criteria: ASAM Adolescent Criteria and Major Connecticut Plans' Criteria

<i>ASAM Dimension</i>	<i>ASAM Adolescent Criteria - Level III.5</i>	<i>ASAM Adolescent Criteria - Level III.7</i>	<i>Plan 1</i>	<i>Plans 2 & 3: <u>Any of the following</u></i>
5. Relapse, continued use, or continued problem potential	Unable to control use and avoid serious impairment because unable to overcome environmental triggers or cravings; or has insufficient supervision between encounters at a less intensive level of care; or high chronicity or response to treatment	Unable to stop high severity or frequency pattern of use and avoid dangerous consequences without high-intensity 24-hr. interventions (because of a condition, severe impulse control problem, withdrawal symptoms, and similar)	Treatment attempted within past 3 mos. has not helped individual achieve abstinence and recovery for reasons other than lack of motivation, participation, or compliance with program recommendations	Continued and severe (see 3a.)
6. Recovery environment	<i>Dangerous to recovery, so requires residential treatment to promote recovery goals or for protection</i>	<i>Dangerous to recovery, so requires residential treatment to promote recovery goals or for protection, and to successfully transition to less intensive level of care</i>		Lacks resources or functional support system needed to manage symptoms in a lower level of care, AND 1.
<p>*A difference from the adult criteria is noted in italics. Source: Program review committee staff comparison of two health plan protocols and the ASAM PPC-2R.</p>				

residential treatment is that the latter are more explicit and encompassing regarding dimension three (Emotional, Behavioral or Cognitive Conditions and Complications). In addition, the “residential treatment center” level of treatment is slightly different: Level III.5 for adults is clinically managed high-intensity, while for adolescents it is clinically managed medium-intensity – with high-intensity medically monitored services at Level III.7. In other words, the ASAM manual does not recognize a level of residential treatment for adolescents that is clinically managed high-intensity.

Results. The comparison in the above tables shows some limited overlap between insurer and ASAM criteria. It also demonstrates that the insurers’ criteria vary in specificity, depth, and comprehensiveness.

The ASAM manual addresses a few issues, in the text preceding the table-form criteria, that are relevant to this discussion of client level of care placement.

1. *Completeness of assessment:* The ASAM manual asserts that the problem severity in all six dimensions should be assessed, when determining medical necessity, specifically noting that “narrow medical concerns (such as severity of withdrawal risk) or psychiatric issues (such as imminent suicidality)” should not determine level of care. One carrier's criteria for residential treatment *require* a complicating medical or psychiatric issue, while another allows for that to determine residential placement.

2. *"Imminent danger":* The ASAM manual states that “imminent danger” should not be limited to “immediate, catastrophic risk.” Instead, it should be evaluated in terms of the “strong probability” that continued use or relapse will occur and “present a significant risk of serious adverse consequences” in the “very near future.”

Program review committee staff reviewed 21 behavioral health coverage denial cases involving Plan 1 with which the Office of the Healthcare Advocate had assisted in the last three years.⁵⁹ In seven of the cases – four involving substance use – the carrier appeared to be using the narrow definition of “imminent harm” against which the ASAM manual cautions.

3. *Balance of goals:* The manual endorses a level of care that is the least intensive while meeting treatment objectives and “providing safety and security for the patient.” Finally, the ASAM manual’s introduction to its adolescent criteria note that, for this population, it is especially important to consider all six dimensions when determining medical necessity (e.g., not only co-occurring ailments). Even when considering all six dimensions, however, a higher level of care than indicated by the criteria may be necessary, because, “The paramount objective should be safety and effectiveness.”⁶⁰

⁵⁹ Patient identifying information had been redacted by the office’s staff. The cases were selected by the office as examples of what the office claims are part of one insurer’s pattern of denying access to behavioral health care in a way that violates the federal mental health parity law. The cases contained materials that varied but included an OHA staff summary of the situation and frequently letters from treating practitioners and/or facilities and the enrollee (or parents).

⁶⁰ Pg. 181

4. *Step-care policies*: The ASAM manual condemns “fail-first” or “step-care” policies, such as that found in Plan 1's criteria, stating:

In fact, the requirement that a person “fail” in outpatient treatment before inpatient treatment is approved is no more rational than treating every patient in an inpatient program or using a fixed length of stay for all. It also does not recognize the obvious parallels between addictive disorders and other chronic diseases such as diabetes or hypertension. Such a strategy potentially puts the patient at risk because it delays a more appropriate level of treatment, and potentially increases healthcare costs if restricting the appropriate level of treatment allows the addictive disorder to progress.

The manual is clear that while failure in a given treatment setting means that adjustment is needed in the treatment plan, level or intensity of care, or treatment strategies, it should not be mandatory before higher levels of care become accessible. It should be noted that a fail-first policy therefore may be in violation of mental health parity laws, because the insurer appears to lack a clinical basis in this respect for treating behavioral health care differently from medical/surgical care.

Other guidelines. The APA and AACAP guidelines are similar in many ways. In terms of general level of care recommendations, each states that clients should be in the least restrictive setting that is safe and – different from ASAM – effective (or, likely to be so). Factors to be considered when determining level of care are the patient’s preference for a particular setting, need for structure, self-care ability, and willingness to engage in treatment.

The psychiatry association guidelines for adults indicate that an initial placement in a residential treatment center is appropriate when:

- the inpatient criteria are not met;
- the person’s life and interactions center on substance use; and
- there are insufficient skills and/or social supports to achieve or maintain abstinence in a less-intensive level of care.

The adolescent psychiatry association parameters for treating substance use disorders are less thorough than the adult guidelines, in terms of explaining criteria for levels of care. They note, however, that while residential programs are appropriate in some cases, “community intervention settings, if feasible, may offer optimal generalization of treatment gains,” perhaps due to the importance of addressing family and peer influences for adolescents.

Length of stay. The ASAM manual addresses length of stay through general “Discharge/Transfer Criteria.” They assert that a stay can be discontinued – with discharge to a higher or lower level of care, as appropriate – when:

- the treatment plan goals have been achieved;
- there has been no resolution of the problems that drove the admission, despite treatment plan adjustment;
- the client has shown incapacity to solve the problems; or

- the problems have changed in type or intensity, in a way requiring higher-level care.

Notably, failing to no longer meet the admission criteria for a given service - as is clear in these plans' criteria - is not explicitly stated as an acceptable reason to end a stay.

The adult psychiatry guidelines explain that the length of stay in a residential treatment center should be whatever is necessary for the person to maintain and build on progress, in a less structured setting. Factors to make that determination could include the person's motivation level, ability to remain substance-free even when drugs are accessible, and living situation and family / peer support of maintaining abstinence.

The ASAM manual and the adult psychiatry guidelines concur that research on the appropriate or most beneficial length of stay for any given setting is problematic and therefore not instructive. However, all three sources state that longer treatment duration is associated with improved outcomes (e.g., reduced or no use).

CID Review of One Carrier's Behavioral Health Protocol

The main body of the report states that one carrier's behavioral health protocol was given to the University of Connecticut medical school's psychiatry department for review in the spring or summer. It was initially anticipated that the results would be ready by October, but as of early December 2012, none had been received and CID had no new projected date.

This was the first time CID requested evaluation of any behavioral health criteria. CID has requested that UConn evaluate whether the protocol reflects the most current standards of care, and whether any provisions violate the state or federal mental health parity laws. The request was made for three reasons.

First, CID observed through its utilization review monitoring and data collection activities that this carrier's behavioral health appeal volume is higher than the other carriers of fully-insured policies.

Second, the department informally asked the carrier about its relatively overall high appeals overturn rate shown by the 2011 Consumer Report Card data. The carrier responded that it believed its criteria were reasonable and being applied appropriately, according to CID.

Third, the Office of the Healthcare Advocate had been communicating with CID for a few years, asserting that its staff believes this carrier's behavioral health criteria are inappropriate, in violation of mental health parity laws due to use of a fail-first requirement, and improperly applied. The Office of the Healthcare Advocate requested a non-scheduled Market Conduct examination of the carrier, but CID did not believe the case-specific documents shared by that office provided sufficient evidence of illegal conduct for that particular step. As noted above, a non-scheduled examination is considered a preliminary enforcement action against the carrier.

The Office of the Healthcare Advocate and the Office of the Attorney General have both had conversations with the U.S. Department of Labor about this carrier's behavioral health care utilization review practices as they relate to mental health parity laws. Program review committee staff contacted the federal labor department to learn how it handles inquiries and complaints generally but its staff would not discuss any particular complaints (these or others).

PRACTITIONER SURVEY DATA

The program review committee staff's survey of practitioners included some questions regarding level of care decisions. The aim of these questions was to help the committee understand on what sources practitioners rely, when making these decisions, and learn whether the practitioners think decisions are consistent.

Sources of decision guidance. Practitioners rely on a range of sources to make decisions about what level of substance use care is required, as the table below shows. Provider-specific guidelines were the most popular written source among survey respondents, and the ASAM manual was the third most frequently cited source.

Table G-3. Survey Respondents' Sources for Substance Use Treatment Level of Care Decisions		
	<i>Percent of Respondents</i>	<i>Number of Respondents</i>
General knowledge	94%	418
Facility-specific guidelines	37%	165
APA guidelines	29%	128
ASAM PPC-2R	21%	95
CT Client Placement Criteria	11%	48
Consultation with colleagues*	6%	28
AACAP guidelines	6%	26
Other national or program guidelines* (e.g., SAMHSA, MDFT)	3%	14
DSM IV*	3%	12
*Wrote-in responses. Notes: There were 444 respondents to this question. Two percent or less of respondents chose or wrote in these responses: A specific screening or assessment tool, insurer criteria, American Academy of Pediatrics guidelines, treatment history, or other sources. Source: PRI staff analysis of practitioner survey data.		

Interestingly, one-third of respondents chose or wrote in at least one source but included no written guidelines. If practitioners are not following written guidelines, there may be more variation in level of care decisions. However, nearly half (48 percent) of respondents not

primarily practicing solo are required by their employer to use a specific decision-making method - which should foster consistency within those workplaces.⁶¹

Perception of decision consistency. A strong majority of respondents indicated that there is mostly agreement among practitioners regarding substance use level of care decisions, as indicated by Table G-4.

Table G-4. Survey Respondents' Perception of How Often Practitioners Agree on Substance Use Level of Care Decisions		
	<i>Percent of Respondents</i>	<i>Percent of Respondents, Excluding "Don't know"</i>
Agree on 25% of decisions or less	2%	2%
26-50%	6%	8%
51-75%	17%	21%
76-90%	30%	37%
91-100%	26%	32%
Don't know	19%	---
Note: There were 369 respondents to this question, but 300 when "don't know" responses were excluded. Source: PRI staff analysis of practitioner survey data.		

Levels of care most often in question. Survey respondents perceived substance use treatment decisions regarding initial placement into inpatient care are those decisions that most often vary. However, initial placement into each traditional level of care was checked by at least 30 percent of respondents. The data did not indicate that the need for residential treatment was perceived to be an area of unusual confusion by survey respondents.

Table G-5. Survey Respondents' Perception of the Levels of Care About Which Substance Use Treatment Decisions Most Often Vary		
	<i>Initial Placement - Percent of Respondents</i>	<i>Extension of Treatment - Percent of Respondents</i>
Detoxification (including setting)	37%	12%
Inpatient	53%	26%
Residential	39%	26%
Wilderness camp	13%	6%
Supervised community living arrangement	12%	9%
Partial hospitalization	31%	17%
Intensive outpatient	40%	23%
Outpatient	34%	18%
Note: There were 322 respondents to this question. Source: PRI staff analysis of practitioner survey data.		

⁶¹ There were 260 respondents who were not solo practitioners for at least half their working hours.

Practitioner Survey Methods

The program review committee staff surveyed licensed and certified behavioral health care practitioners to gather information directly from the people who treat clients with substance use and co-occurring disorders. The survey responses offer insight on treatment decisions and experiences with health carriers.

Distribution

Program review committee staff conducted electronic and mail surveys that essentially contained the same introduction and questions. Both surveys were distributed in late September 2012 to people with the following licensure or certification types:

- alcohol and drug counselors (both licensed, LADC, and certified, CADC);
- clinical social workers (LCSW);
- professional counselors (LPC);
- marriage and family therapists (LMFT);
- psychiatrists (a sub-category of physician)⁶²; and
- psychologists.

Electronic. The Department of Public Health (DPH) does not collect and retain e-mail addresses for any licensed or certified behavioral health care practitioners. Consequently, program review committee staff attempted to contact the relevant professional association for each practitioner type and secure the association's agreement to distribute the survey to its membership electronically. Three associations - social workers, counselors, and psychiatrists - did so, and another - psychologists - agreed to place a link to the survey in its electronic newsletters. At least two of the associations also sent out electronic reminders containing the survey link.

Postal mail. Program review committee staff mailed a hard-copy survey to half the practitioners within each category (e.g., psychiatrist), using a random selection method. A reminder postcard was sent approximately one week later.

Practitioners whose addresses were outside Connecticut or who were known to have received the web-based version of the survey were excluded from the initial list used to select survey recipients.⁶³

⁶² Physician subspecialty was not shown on the DPH data for about 21 percent of physicians. It is likely that some psychiatrists were among them, and therefore that psychiatrists may have been under-sampled.

⁶³ Two of the four associations that agreed to send the web-based version of the survey to their membership also made it possible for program review committee staff to avoid sending those members a hard copy of the survey.

Response Rates

The overall response rate from the electronic survey was quite low; only about four percent of all recipients completed it. The effective response rate for the target group of licensed and practicing members is likely somewhat higher, since an unknown portion of any professional group's membership includes those who are not licensed or practicing (e.g., retired people, students in training).

As shown in the table below, the overall response rate from the mail survey was 21.5 percent, below the goal of 25 percent. It is the opinion of the committee that the survey data are still worth considering and presenting because it is likely a large portion of non-respondents did not practice in the area of youth substance use at the time of the survey. Although the survey itself asked recipients to return the survey if the first few questions indicated they did not need to complete the remainder, the introductory letter or e-mail to the survey did not contain similar language. Further, the introduction was quite clear that the aim of the survey was to collect information on experiences in providing youth substance use treatment services.

The precise response rate for any licensure or certification group cannot be determined. Many practitioners have more than one type of license and the surveys were unmarked by program review staff, to ensure respondents were comfortable with the survey's anonymity. Neither can it be determined whether any particular type of practitioner - in the universe of those providing treatment to youth with a substance use disorder or problem - was over- or under-represented.

Table H-1. Mailed Practitioner Survey Distribution and Response			
	<i># Licensed and In Pool*</i>	<i># Mailed Survey</i>	<i>Response Rate**</i>
Alcohol and drug counselor (certified - CADC)	255	128	21.5%
Alcohol and drug counselor (licensed - LADC)	638	319	
Clinical social worker (LCSW)	2,758	2,758	
Marital and family therapist (LMFT)	950	475	
Professional counselor (LPC)	1,552	776	
Psychiatrist	374	187	
Psychologist	1,522	761	
TOTAL	8,049	4,025	
<p>* With a Connecticut address for licensure purposes, and excluding those known to have received a survey electronically via a professional association.</p> <p>**The 35 surveys returned to the program review committee due to invalid addresses were subtracted from the number sent, when determining the response rate. The committee received 843 completed surveys and 14 phone responses indicating the practitioner was not currently providing treatment to clients with substance use or co-occurring disorders, for a total of 857 responses to the mailed survey.</p>			

Data Entry and Analysis

The responses to the mailed survey were entered electronically into separate Excel workbooks by administrative assistants from the program review committee staff and the Offices of the Legislative Commissioners', Fiscal Analysis, and Legislative Research. The data were combined by program review committee staff, and then the web survey responses were added.

The resulting dataset, consisting of information from 950 survey respondents, was analyzed by the committee staff. Of the 950 respondents, 457 (47 percent) currently were providing counseling or other treatment to at least one client with a substance use or co-occurring disorder. All data presented below and in the body of the report comes from this core group of interest, except where noted.

Respondent Characteristics

Licensure type. The largest single licensure group of respondents was licensed clinical social workers (LCSWs), consisting of about one-third of all respondents. Licensure type for both all respondents and those whose work is directly relevant to this study is shown in the table below. Many respondents held multiple licenses.

Table H-2. Licenses Held By Survey Respondents				
	<i>All Respondents</i> (n=950)		<i>Relevant Respondents</i> (n=457)	
	#	% of n	#	% of n
CADC	58	6%	36	8%
LADC	116	12%	89	19%
LCSW	343	36%	149	33%
LMFT	119	13%	71	16%
LPC	197	21%	96	21%
Psychiatrist	45	5%	26	6%
Psychologist	166	17%	70	15%
Note: Because many respondents held multiple licenses, the percentages do not sum to 100. Source: Program review committee staff analysis of survey data.				

Work setting. The settings in which relevant respondents were employed varied, but about half (51 percent) maintained a solo counseling practice for at least part of their working hours. The second most frequent employer, at 28 percent, was a social services or behavioral health provider. The table below shows those and the other employment settings for the 457 respondents whose work is relevant to this study.

Table H-3. Employment Settings of Survey Respondents		
	Relevant Respondents (n=457)	
	#	%
Solo counseling practice	235	51%
Group counseling practice	73	16%
School (K-12) counseling	25	5%
College counseling	9	2%
Social services / behavioral health provider	128	28%
Hospital	85	19%
Medical clinic	9	2%
Note: Because many respondents worked in multiple settings, the percentages do not sum to 100. Source: Program review committee staff analysis of survey data.		

Level of care. A strong majority of respondents (84 percent) offered outpatient treatment. There was representation, however, from all the traditional levels of levels of care, as conveyed by Table H-4.

Table H-4. Levels of Care Offered by Survey Respondents		
	Relevant Respondents (n=457)	
	#	%
Inpatient	44	10%
Residential treatment	30	7%
Partial hospitalization	47	10%
Day / evening treatment	88	19%
Intensive outpatient	86	19%
Outpatient	385	84%
Note: Because many respondents offered more than one level of care, the percentages do not sum to 100. Source: Program review committee staff analysis of survey data.		

Clients. The percentage of respondents' clients who have a substance use or co-occurring disorder averaged 41 percent. The median, however, was 70 percent. The difference between the two measures indicates that there was a substantial portion of respondents who had a small share of clients with one of these disorders.

Among respondents' clients with a substance use or co-occurring disorder, about one quarter are young (25 years and under). The mean and median are very close - 28 and 25 percent, respectively.

Appendix I

Medicaid Behavioral Health Partnership (BHP) Utilization Review Process: Details

STANDARD BHP PROCESS

Federal Medicaid regulations give states the ability to create and carry out their own utilization review processes for health services given under the program. For Connecticut's behavioral health Medicaid program, ValueOptions conducts utilization review but it has no financial incentive to deny care because Value Options does not pay claims, and claims payment is made on a fee for service basis (instead of a capitated rate). The arrangement is the same for Connecticut Medicaid's medical services, which use a different administrative services organization.

Initial Determinations (Prospective Review)

A provider makes an authorization request via telephone or web registration on the ValueOptions secured web portal.

When a denial is issued (whether appealed or not), ValueOptions reports that its reviewer staff proactively works with the provider to match the client to the appropriate level of care. For example, if someone was denied coverage for hospital detoxification, the provider would be told that although medical management at a hospital level is unnecessary in this case, residential detoxification would be appropriate.

Timeframes. The timeframes for the initial authorization are performance standards in the BHP contract; they are not set by state law. The timeframes vary according to the level of care as shown below. For example, in the case of an inpatient admission, the final decision must be made within two hours. Within the first hour of having received all necessary information, the initial review and physician review (if the first reviewer believes a denial is in order) must be completed. Then, the physician reviewer has an additional hour to make the decision.

Table I-1. Utilization Review Preauthorization Decision Time Limits			
<i>Level of Care</i>	<i>Max. Time for Initial Review + (if necessary) Peer Review</i>	<i>Max. Time for Decision</i>	<i>Max. Total Time to Decision Notification</i>
Inpatient	1 hour	1 hour	2 hours
Detoxification (Inpatient or Res.)	2 hour	1 hours	3 hours
Residential Rehab. Partial Hospitalization Extended Day Intensive Outpatient Outpatient and all other services	1 business day		
Source: PRI staff analysis of DSS information.			

Concurrent review for extending the stay of higher levels of care (partial hospitalization and above) must be completed within one business day, under the BHP contract terms. Concurrent review for intensive and regular outpatient has to be conducted within two business days (except for Home Health services).

Nearly all services are preauthorized and/or concurrently reviewed. Retrospective review is conducted only when two conditions are met. First, an enrollee's BHP eligibility has changed to cover services that have already been rendered. Second, the provider – unlike most BHP providers – did not initially request preauthorization based on presumptive eligibility. Retrospective review is completed within 30 days of a request for payment, as long as the service was initiated no more than 90 days ago and a final determination on eligibility was made before the client's services ended.

All ValueOptions coverage decisions are transmitted to the provider through electronic letters available on the provider's ValueOptions web page portal.

Medical necessity definition. States also have the ability – or, responsibility – under federal regulation to define “medical necessity” for their Medicaid programs, with one exception (explained below).⁶⁴ Connecticut Medicaid's definition is in statute, and it applies to both the medical and behavioral health care programs.

Connecticut's Medicaid definition of medical necessity, found in C.G.S. Sec. 17b-259b, is:

(a) For purposes of the administration of the medical assistance programs by the Department of Social Services, "medically necessary" and "medical necessity" mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are:

(1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors;

(2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease;

(3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers;

⁶⁴ 42 CFR Sec. 440.230(d)

(4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and

(5) based on an assessment of the individual and his or her medical condition.

(b) Clinical policies, medical policies, clinical criteria or any other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested health service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity.

This definition is somewhat more expansive than the definition that applies to fully-insured private insurance plans in the state by specifically including:

- amelioration and rehabilitation in “treatment;”
- mental illness;
- treatment that is given to “attain or maintain the individual’s achievable health and independent functioning;” and
- specialty society recommendations, views of physicians practicing in relevant clinical areas, and other relevant factors, as the bases for generally-accepted practice standards.

The statute also asserts that protocols or other practice guidelines can only be used to “assist in evaluating” medical necessity – not as the basis for the final determination.

This state-specific definition is used for Connecticut adult Medicaid services. It was developed by the Medical Inefficiency Committee, which was created and charged by statute with proposing a new definition of medical necessity for Medicaid. (Previously, state regulations contained definitions for, separately, medical appropriateness and medical necessity.) The committee, composed largely of providers and patient advocates, considered medical necessity definitions used in other states and various requirements set out in its authorizing statute. The committee’s proposal became law in P.A. 10-3.

Nationwide, services for children under the original Medicaid program (HUSKY A, in Connecticut) fall under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. A wide range of listed services is required. In addition, the federal law elaborates that the Medicaid program for children must cover any other health care services (diagnosis or treatment) “to correct or ameliorate defects and physical and mental illnesses and conditions.”⁶⁵

⁶⁵ Social Security Act, Section 1905(r)(5). Accessed August 23, 2012 at: http://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

ValueOptions and DSS staff asserted that while the federal EPSDT language prescribes the medical necessity definition for children in traditional Medicaid in a way that would usually broaden it compared to adult coverage, there is little effect on BHP services because the program's benefits are generous, compared to other states.' If there is a request made that invokes EPSDT and prescribes a service or treatment not within the BHP's regular scope of services, then that request is evaluated by ValueOptions for medical necessity and whether the service falls under the EPSDT definition.

Currently there is a disagreement between DSS (and by extension ValueOptions, as its BHP administrative services organization) and some advocates relating to this issue. Applied behavior analysis (ABA) therapy for autism is not included in HUSKY services, but practitioners have been requesting coverage for it – and getting denied.⁶⁶ One legal services staff person reported to program review committee staff that recently practitioners have been told they can no longer even request coverage.

ValueOptions and various state agency staff confirmed that, consistent with the statute, a denial must be based not on the medical protocol, but on how the medical necessity definition applies in a particular situation. The BHP guidelines for adults and children both note that a request which does not meet the protocol's criteria has to be assessed to determine whether the services are medically necessary under the statutory definition or, for those under 21 years old, are included under EPSDT.

Protocols. Under the BHP contract, the protocols are reviewed annually. ValueOptions clinical staff send recommended changes (after the organization's internal review) to the BHP Clinical Management Committee, which consists of providers, clients, and state agency personnel. The committee researches and votes on the recommendations. Changes approved are sent on to the BHP's Operations Committee and then to its Oversight Council for final acceptance. The Oversight Council consists of practitioners, larger providers, enrollees and/or parents of enrollees, and state agency representation, among others.

Notification. All ValueOptions authorization decisions are posted on the organization's secure web portal. Notices of denials are sent to the provider and enrollee via certified mail.

Appeals

Provider appeals. A provider may notify ValueOptions that s/he is appealing a denial based on medical necessity within seven calendar days of denial receipt. A ValueOptions psychiatrist or physician who was uninvolved in the initial determination – and is not supervised by the initial decision-maker – is assigned the case.

The reviewer attempts to have a conversation with the provider and examines all documentation. A decision must be made within one business day of receiving the request.

⁶⁶ See, for example:

[http://www.ctmirror.org/sites/default/files/documents/Autism%20Treatment%20ABA%20Services%20Letter%20to%20Bremby%20Final%209%2029%2011%20\(3\).pdf](http://www.ctmirror.org/sites/default/files/documents/Autism%20Treatment%20ABA%20Services%20Letter%20to%20Bremby%20Final%209%2029%2011%20(3).pdf).

If the denial was upheld, the provider may notify ValueOptions that s/he wishes to appeal again, within 14 calendar days. The provider is required to submit the enrollee’s medical record within 30 days of that request. This second appeal’s result is determined by a ValueOptions psychiatrist who was not involved in or supervised by anyone participating in the previous decisions. A judgment must be made and shared with the provider within five business days of receiving the medical record.

Enrollee appeals. The appeals process available to an enrollee has two separate steps – internal appeal and a state fair hearing – when there has been a denial based on medical necessity.

Internal appeal. There are three internal appeal options: standard, expedited, and expedited when in the emergency department. In each, the reviewer must meet the same credential and decision involvement requirements as in the provider process described above. The chart below shows the requirements for the internal appeals processes available to enrollees.

Table I-2. Internal Appeal Processes Available to BHP Enrollees			
<i>Type</i>	<i>Appeal filing requirement (from receipt of denial notice)</i>	<i>Enrollee – Reviewer Meeting (at enrollee request)</i>	<i>Time to Decision, from Appeal Request Receipt</i>
Standard	Within 60 days	Scheduled within 14 days of appeal request receipt	30 days*
Expedited	None; generally done immediately	Scheduled within 3 business days of appeal request receipt	3 business days if no meeting; or 5 business days if was meeting
Expedited – Member in Emergency Dept.	Immediately	None	1 day**
*Or, by the date of the DSS administrative hearing, whichever is earlier. **When this process is requested, a single-day “provisional authorization” for admission is given, pending the results of the appeal. Source: DSS-provided table.			

When an internal appeal request is submitted, the request sets in motion both the internal appeal and fair hearing processes. The internal appeal progresses and the fair hearing is scheduled within 30 days of the request’s receipt. If the internal appeal is successful for the enrollee, then the fair hearing process ends.

Fair hearing. A state fair hearing process must be available, under federal law and regulation, to someone who is denied Medicaid coverage (either overall or based on medical necessity of a particular treatment). An enrollee can pursue this process at any point; it is separate and distinct from the provider appeal process.

The fair hearing process is governed by federal and state law. Under federal law, the state Medicaid program must give a person written notice of appeal rights when an application for benefits is submitted and when a claim is acted upon. When eligibility or coverage is adversely affected, the notification must include:

- the law or policy reason for the action, and how that reason applies to this particular case;
- the right to request a hearing; and
- instructions on how to request a hearing, and notice that the person can represent themselves or choose to be represented by legal counsel, a relative, or another person.

If a Connecticut HUSKY A, C, or D enrollee (or potential enrollee) wishes to request a hearing, then a request must be made to DSS. The request form is included in the denial letter envelope as required by federal law, and is also available on the DSS website.

A state may limit the time period for filing a fair hearing request to between 20 and 90 days from the date the notice was sent; Connecticut state law prescribes 60 days. Under federal law, a person can request that benefits continue while the appeal is pending, if the request is made within 10 days of the scheduled action.

DSS must grant the request for the hearing unless the person withdraws the request in writing. The fair hearing must be scheduled for within 30 days of the request, and the person has to be given at least ten days' notice of the hearing date.⁶⁷

When a fair hearing involving BHP benefits or enrollment is requested, DSS notifies ValueOptions. That company sends DSS a summary of the case at least five business days before the scheduled hearing. DSS reviews the summary and has the authority to override the decision, which agency staff said has not occurred in at least the past three years. DSS's fair hearing unit then notifies the enrollee of the acceptance and handles hearing logistics.

DSS fair hearings are held by videoconference. The enrollee and, if the person chooses, their representative, goes to a DSS regional office, where the fair hearing officer also is located. DSS fair hearings regarding BHP involve a ValueOptions staff member (generally a medical director) and someone from the age-corresponding state agency – DCF for a child, DMHAS for an adult. As with all DSS fair hearings, each side presents their argument and the hearing officer asks clarifying questions and for any additional information. The hearing officer adjourns the meeting and gives the decision, in writing, within 60 days.⁶⁸

The same timeframes and general process apply for fair hearing requests filed on behalf of DCF Limited Benefit enrollees. However, DCF handles the process, and the hearing usually is held in-person at one of the department's 15 area offices.

⁶⁷ C.G.S. Sec. 17b-60

⁶⁸ C.G.S. Sec. 17b-61

HUSKY B and Charter Oak members may request an external review that uses a different method. An enrollee who has exhausted the internal appeal process can file for a review within 30 days of the final denial notice. Then, a high-level DSS staff person who is a licensed practitioner in the area relevant to the request (behavioral health, medical care, or dental) conducts a desk review of the request by examining the information supplied by ValueOptions. The DSS staffperson has 30 days to make a decision on a regular appeal, or 48 hours for an expedited appeal. DSS staff report that to the best of their knowledge, this process has not been used.

If the decision was adverse, the enrollee may appeal the decision to the Superior Court, within 45 days. DSS was not aware of any such action for a BHP denial.

HUSKY D RESIDENTIAL TREATMENT PROCESS

For this enrollee population and particular category of care, DMHAS oversees utilization review, which is conducted by Advanced Behavioral Health. In this context, residential treatment includes a variety of settings and strength, ranging from intensive residential - which generally involves 10 to 14 days initially - to long-term residential options.

Initial Determinations

The initial reviewer must be licensed and have had at least five years' experience in providing mental health and substance use services. If it appears a denial may be in order, the reviewer must consult with a Connecticut-licensed psychiatrist with addiction board certification. (These requirements apply to all DMHAS services handled by the ASO.) A medical necessity decision is based on the ASAM PPC-2R, the Connecticut Client Placement Criteria, and the statutory definition of medical necessity. The coverage decision must be made within three hours of the receipt of all necessary information.

Appeals

Internal. If a denial is issued, an internal appeal may be requested within seven days, by either the provider or the enrollee. The internal appeal decision has to be made by the ASO within seven days of the request's receipt.

A second-level internal appeal may also be sought, again by either party and within seven days of the (second) denial notice. However, DMHAS staff make the decision, in this case. Usually this person is the manager of the clinical side of DMHAS's Behavioral Health Recovery Program (its entire service array). The position was vacant as of early November 2012; a licensed clinician with other duties had the role of second-level appeals decision-maker. Regardless of who it is, the DMHAS staff person has seven days to determine the appeals result.

External. The external appeal, available only to enrollees, is the state fair hearing process. DMHAS administers the process, which mainly follows the same timeframe and other requirements as the BHP state fair hearing process described above. The exception is that an external appeal must be requested within 30 days of DMHAS's second-level appeal decision. There have not yet been any fair hearings requested for HUSKY D residential treatment.

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Recent Medicaid (BHP) Utilization Review Data

Behavioral Health Partnership (BHP) utilization review and appeals data (including, separately, for HUSKY D residential treatment) were requested and provided for 2009, 2010, and 2011. In addition, program review committee staff's practitioner survey (described in Section II and Appendix G) included questions about Medicaid. Results from the survey are interspersed below, where relevant. These results are limited to those respondents (n=457) who indicated they currently are counseling at least one client with a substance use or co-occurring disorder.

Context

The BHP had more than 153,000 youth enrollees in 2009, as shown in Table J-1. By 2011, the number had climbed to 200,000 - an increase of 30 percent. Part of the increase is attributable to the addition of HUSKY D to the BHP. About one in eight BHP youth enrollees annually received at least one type of mental health or substance use care, from 2009 through 2011.

Table J-1. BHP Youth Enrollment and Utilization, 2009-2011*				
	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2009-2011</i>
Ages 12-17				
Number of enrollees	92,975	98,746	105,783	297,504
Number of enrollees received care	10,889	11,717	12,259	34,865
Percent received care	12%	12%	12%	12%
Ages 18-25				
Number of enrollees	60,509	64,493	94,134	219,136
Number of enrollees received care	5,747	6,014	12,817	24,578
Percent received care	9%	9%	14%	11%
Total youth (12-25)				
Number of enrollees	153,484	163,239	199,917	516,640
Number of enrollees received care	16,636	17,731	25,076	59,443
Percent received care	11%	11%	13%	12%
*Excluding HUSKY D residential treatment. Source: PRI staff analysis of BHP data.				

Initial Determinations

BHP. Program review committee staff analyzed utilization review data for the treatment categories that involved substance use and had - or could potentially have - analogous options available to those enrolled in commercial health plans. These data are the most relevant to the study and narrows somewhat the amount of information presented, for the reader. However, the data therefore are limited and do not represent the universe of either BHP available services or

BHP utilization review decisions. These excluded requests were about 7.6 percent of all BHP requests involving youth, from 2009 through 2011.

Another caveat is that data were pulled by year. The number of requests, full denials, partial denials, appeals, and appeals overturned were given for each year - not according to in which year the request originated. Consequently, the percent-oriented data on determinations and appeals are estimates.

Table J-2. BHP Youth (Ages 12-25) Requests for Treatment Categories Relevant to Substance Use, Overall and By Diagnosis, 2009-2011^a					
	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2009-2011</i>	<i>% of all/ diagnosis</i>
All included categories ^b	25,098	26,610	39,919	91,627	100%
Substance use + co-occurring	4,790	4,590	10,285	19,665	21%
Mental health	19,072	20,805	29,561	69,438	76%
Inpatient and Other acute	3,318	3,369	5,280	11,967	13%
Substance use + co-occurring	705	649	1,832	3,186	16%
Mental health	2,607	2,716	3,448	8,771	13%
Residential ^c	130	143	88	361	0%
Substance use + co-occurring	129	139	84	352	2%
Partial hospitalization	996	1,035	1,386	3,417	4%
Substance use + co-occurring	257	240	535	1,032	5%
Mental health	736	795	851	2,382	3%
Intensive outpatient and Extended day treatment	2,275	2,467	4,080	8,822	10%
Substance use + co-occurring	8,64	929	2,253	4,046	21%
Mental health	1,410	1,535	1,827	4,772	7%
Outpatient counseling	16,646	17,631	26,004	60,281	66%
Substance use + co-occurring	2,389	2,264	4,417	9,070	46%
Mental health	13,036	14,164	21,519	48,719	70%
Outpatient substance treatment ^d	318	263	1,081	1,662	2%
Substance use + co-occurring	316	261	1,010	1,587	8%
Mental health	1	2	70	73	0%
Home-based models	1,415	1,702	2,000	5,117	6%
Substance use + co-occurring	130	108	154	392	2%
Mental health	1,282	1,593	1,846	4,721	7%

^a Treatment options for which there no commercial insurance equivalents or that are not aimed at assisting people with substance use or co-occurring disorders, such as types of congregate care, have been excluded from this and subsequent charts.

^b The Substance use + Co-occurring and Mental health categories frequently do not sum to the overall number shown, here and in the shaded rows, because the overall number includes requests for which no diagnosis was available.

^c According to BHP, there is no true mental health equivalent of substance use residential treatment. Also, these figures exclude HUSKY D enrollees, who have a different utilization review arrangement for this service type.

^d Ambulatory detoxification and methadone maintenance.

Source: PRI staff analysis of BHP data.

Between 2010 and 2011, when BHP assumed responsibility for HUSKY D, the number of requests increased by 50 percent, to nearly 40,000, as indicated by Table J-2. Of those, about one-fourth were for clients with a substance use or co-occurring disorders diagnosis - a slightly larger share than for 2009 through 2011 combined.

The largest category for requests was, by far, outpatient counseling, which accounted for 66 percent of all requests, and 46 percent of requests involving a client with a substance use-related diagnosis. Table J-3 shows nearly all (99 percent) requests for treatment were fully approved. The approval rate specific to those with substance use and co-occurring disorders - limited to treatment at or above the level of intensive outpatient / extended day treatment - was 96 percent.

Table J-3. Estimated Percent of BHP Youth (Ages 12-25) Requests Fully Approved, for Treatment Categories Relevant to Substance Use, Overall and By Diagnosis, 2009-2011^a

	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2009-2011</i>
All categories ^b	99	99	98	99
Substance use + co-occurring	98	98	98	98
Mental health	98	99	98	98
Inpatient and Other acute	96	96	98	97
Substance use + co-occurring	96	97	98	97
Mental health	96	96	97	97
Residential ^c	93	98	95	96
Substance use + co-occurring	94	98	98	96
Partial hospitalization	98	98	98	98
Substance use + co-occurring	100	99	99	99
Mental health	99	98	98	98
Intensive outpatient and Extended day treatment	97	96	93	95
Substance use + co-occurring	96	94	93	94
Mental health	98	97	94	96
Outpatient counseling	100	99	99	99
Substance use + co-occurring	100	100	100	100
Mental health	100	99	99	99
Outpatient substance treatment ^d	100	100	99	99
Substance use + co-occurring	100	100	99	99
Mental health	100	100	99	99
Home-based models	92	98	97	96
Substance use + co-occurring	86	99	100	95
Mental health	93	98	97	96

^a Treatment options for which there no commercial insurance equivalents or that are not aimed at assisting people with substance use or co-occurring disorders, such as types of congregate care, have been excluded from this and subsequent charts.

^b The Substance use + co-occurring and Mental health categories frequently do not sum to the overall number shown, here and in the shaded rows, because the overall number includes requests for which no diagnosis was available.

^c According to BHP, there is no true mental health equivalent of substance use residential treatment.

^d Ambulatory detoxification and methadone maintenance.

Source: PRI staff analysis of BHP data.

The lowest three-year (2009 through 2011) approval rate was 95 percent, for intensive outpatient and extended day treatment, which both offer 3 hours of treatment daily. It is important to note that extended day treatment generally is for mental health treatment; it was included because a small number of enrollees requesting the service had co-occurring disorders and the service intensity (three hours daily) is the same for it and intensive outpatient.

The data provided by DSS and presented in Table J-4 show three-quarters of denials from 2009 through 2011 were partial, not full - meaning that a shorter service duration was approved than the provider sought. The rate of partial denials was lowest for residential treatment - meaning, it was the category of services that had the highest rate of full (versus partial) denials. It is important to keep in mind, however, that the number of denials (full and partial) for the category was the lowest among the service categories for each year. There were 16 residential treatment denials across the three years, and only four in 2011, the year in which the partial denial rate was lowest.

In DSS's response to a preliminary, partial draft of this report, the department asserted that there were no partial denials issued by BHP from 2007 through 2011. DSS reported that the practice was to either fully deny the request or record approval of a negotiated, modified request. In 2011, the department directed ValueOptions to record partial denials if there was not complete agreement with the request, based on recommendations from the Medical Inefficiency Committee. To implement this change, ValueOptions staff were instructed through re-training to issue a partial denial if the provider did not agree with the coverage decision. The program review committee has no reason to doubt this change, but notes partial denial data for 2009 through 2011 were earlier provided.

Table J-4. Estimated Percent of BHP Youth (Ages 12-25) Denials that Were Partial (not full) Denials, for Treatment Categories Relevant to Substance Use, Overall and By Diagnosis, 2009-2011^a				
	2009	2010	2011	2009-2011
All categories ^b	73	76	76	75
Substance use + co-occurring	74	81	93	86
Mental health	83	79	69	76
Inpatient and Other acute	56	63	63	61
Substance use + co-occurring	55	68	63	61
Mental health	59	64	63	62
Residential ^c	56	67	25	50
Substance use + co-occurring	63	67	50	62
Partial hospitalization	73	79	91	82
Substance use + co-occurring	100	100	80	89
Mental health	91	75	94	86
Intensive outpatient and Extended day treatment	88	78	94	89
Substance use + co-occurring	84	83	99	93
Mental health	94	78	86	86
Outpatient counseling	92	89	60	74
Substance use + co-occurring	80	100	100	96
Mental health	97	92	56	73
Outpatient substance treatment ^d	100	100	90	92
Substance use + co-occurring	100	100	100	100
Mental health	---	---	0	0
Home-based models	93	93	84	91
Substance use + co-occurring	89	100	---	89
Mental health	96	93	84	92

^a Treatment options for which there no commercial insurance equivalents or that are not aimed at assisting people with substance use or co-occurring disorders, such as types of congregate care, have been excluded from this and subsequent charts.

^b The Substance use + co-occurring and Mental health categories frequently do not sum to the overall number shown, here and in the shaded rows, because the overall number includes requests for which no diagnosis was available.

^c According to BHP, there is no true mental health equivalent of substance use residential treatment.

^d Ambulatory detoxification and methadone maintenance.

Source: PRI staff analysis of BHP data.

HUSKY D residential treatment data. Residential treatment was sought by a very small portion - between about two and four percent - of HUSKY D young adult clients annually, between 2009 and 2011, as indicated by Table J-5. Most of the enrollees seeking this type of treatment had a substance use disorder diagnosis, instead of a co-occurring disorders diagnosis.

Table J-5. HUSKY D Young Adult (18-25) Enrollment and Unique Enrollee (by year) Requests for Substance Use Residential Treatment, 2009-2011				
	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2009-2011</i>
Enrollees	11,251	17,555	24,774	53,580
Enrollees with at least one residential treatment coverage request	445	443	454	1,342
Substance use diagnosis	279	268	288	835
Co-occurring diagnosis	166	175	166	507
Percent of enrollees with at least one residential treatment coverage request	4.0%	2.5%	1.8%	2.5%
Substance use diagnosis	2.5%	1.5%	1.2%	1.6%
Co-occurring diagnosis	1.5%	1.0%	0.7%	0.9%

Source: PRI staff analysis of DMHAS data.

Table J-6 shows there were annually more than 1,300 coverage requests for HUSKY D residential treatment for young adult enrollees. The number of coverage requests - both overall and by diagnosis - is, for each year, more than twice the number of unique enrollees who had a coverage request (shown by the previous table). This means that the average number of requests including all timings (prospective, concurrent, and retrospective) was at least two per enrollee who sought this treatment.

Table J-6. Total Coverage Requests for HUSKY D Young Adult Residential Substance Use Treatment by Diagnosis, 2009-2011								
	<i>2009</i>		<i>2010</i>		<i>2011</i>		<i>2009-2011</i>	
	#	%	#	%	#	%	#	%
Substance use	829	61%	875	63%	900	61%	2,604	62%
Co-occurring	527	39%	525	38%	572	39%	1,624	38%
Total	1,356	100%	1,400	100%	1,472	100%	4,228	100%

Source: PRI staff analysis of DMHAS data.

There were no retrospective requests for coverage of residential treatment, in 2009 through 2011, as indicated by Table J-7. A majority of requests - about 60 percent - were for concurrent review. For this client group and type of care, concurrent review is only conducted when an extension of stay has been requested. (For other BHP and commercial insurance enrollees, it may also be done when prospective review did not occur before services began.)

Table J-7. Coverage Requests by Timing for HUSKY D Young Adult Residential Substance Use Treatment, 2009-2011				
	2009	2010	2011	2009-2011
Prospective	568	567	575	1,710
Substance use	337	341	342	1,020
Co-occurring	231	226	233	690
Concurrent	788	833	897	2,518
Substance use	492	534	559	1,585
Co-occurring	296	299	339	934
Retrospective	0	0	0	0
Percent of requests				
Prospective	42%	41%	39%	40%
Concurrent	58%	60%	61%	60%
Source: PRI staff analysis of DMHAS data.				

The most interesting aspect of the HUSKY D residential treatment utilization review data is that there were no denials - either partial or full - in any of the three years examined. This is unique among all three sets of data examined by PRI staff: commercial fully-insured plans, overall BHP, and this BHP subset. DMHAS staff asserted there are likely two factors that make the denial rate very low. (For all ages, the rate is about 0.2%, according to the department).

First, these clients often are on HUSKY D because they cannot work due to substance use problems. This fact indicates the substance use is usually severe and the person is in need of high-level care. Frequently the clients are stepping down to residential treatment from inpatient or detoxification care.

Second, when considering whether to accept a potential client for treatment or when a current provider is looking to make a referral to another level of treatment, often a facility will call the ASO to see what would be covered. Based on the ASO's feedback, the request may be adjusted in terms of level of care and/or length of stay. If this happens before coverage authorization has been formally sought, then there has not truly been a denial.

Internal Appeals

All BHP data. Up to 43 percent of BHP denials relevant to this study were appealed, in 2009 through 2011, as shown in the table below. Each percent calculation should be considered both an estimate (for the timeframe reason given above) and a maximum, because every appeal made is individually counted. Consequently, an individual request (which, summed, is the denominator in the appeals rate calculations) may have up to three associated internal appeals.

The three-year appeals rate for denials involving care for those with substance use or co-occurring disorders was substantially lower than the comparable rate for enrollees with a mental health diagnosis. The rate for intensive outpatient and extended day treatment was particularly low for intensive outpatient and extended day treatment - the category that narrowly had the lowest (though still robust) full approval rate, for people with substance use or co-occurring disorders.

It is unclear precisely why these appeals rates, for substance use-related treatment, generally are relatively low. However, it is likely that the small number of denials plays a strong role. Where there were few denials - as was true for all categories except intensive outpatient and extended day treatment - the percent appealed is easily influenced.

Table J-8. Number and Estimated Maximum Percent of BHP Youth (Ages 12-25) Denials Appealed, for Treatment Categories Relevant to Substance Use, Overall and By Diagnosis, 2009-2011^a

	<i>Number of Appeals</i>				<i>Est. Max. Percent of Denials Appealed</i>			
	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2009-2011</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2009-2011</i>
All categories ^b	177	161	304	642	42%	41%	44%	43%
Substance use + co-occurring	25	12	25	62	27%	13%	11%	15%
Mental health	128	129	236	493	41%	44%	51%	46%
Inpatient and Other acute	37	40	46	123	26%	30%	38%	31%
Substance use + co-occurring	7	7	12	26	24%	37%	34%	31%
Mental health	25	32	34	91	24%	29%	39%	30%
Residential ^c	8	1	2	11	89%	33%	50%	69%
Substance use + co-occurring	6	1	0	7	75%	33%	0%	54%
Partial hospitalization	9	12	13	34	60%	63%	59%	61%
Substance use + co-occurring	0	1	2	3	0%	33%	40%	33%
Mental health	7	11	11	29	64%	69%	65%	66%
Intensive outpatient and Extended day treatment	35	41	99	175	52%	40%	37%	40%
Substance use + co-occurring	1	2	5	8	3%	3%	3%	3%
Mental health	24	23	54	101	69%	56%	50%	55%
Outpatient counseling	27	51	104	182	37%	49%	50%	47%
Substance use + co-occurring	1	0	5	6	20%	0%	31%	23%
Mental health	23	48	99	170	35%	50%	51%	48%
Outpatient substance treatment ^d	1	0	2	3	100%	0%	20%	25%
Substance use + co-occurring	1	0	2	3	100%	0%	20%	25%
Mental health	---	---	0	0	---	---	0%	0%
Home-based models	60	16	38	114	52%	53%	66%	56%
Substance use + co-occurring	9	1	0	10	50%	100%	---	53%
Mental health	49	15	38	102	52%	52%	66%	56%

^a Treatment options for which there no commercial insurance equivalents or that are not aimed at assisting people with substance use or co-occurring disorders, such as types of congregate care, have been excluded from this and subsequent charts.

^b The Substance use + co-occurring and Mental health categories frequently will not sum to the overall number shown, here and in the shaded rows, because the overall number includes requests for which no diagnosis was available.

^c According to BHP, there is no true mental health equivalent of substance use residential treatment.

^d Ambulatory detoxification and methadone maintenance.

Source: PRI staff analysis of BHP data.

Across categories of care, about 29 percent of all appeals were decided in favor of the requesting provider or enrollee, as shown in Table J-9. The data are not broken down into related appeals and overturns; consequently, it is impossible to tell what, for an average request, is the ultimate chance of appeals success.

Table J-9. Number and Estimated Percent of BHP Youth (Ages 12-25) Appeals Resulting in Overturn, for Treatment Categories Relevant to Substance Use, Overall and By Diagnosis, 2009-2011^a

	<i>Number of Overturns</i>				<i>Est. Percent of Appeals Overturned</i>			
	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2009-2011</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2009-2011</i>
All categories ^b	44	30	110	184	25%	19%	36%	29%
Substance use + co-occurring	8	2	11	21	32%	17%	44%	34%
Mental health	31	28	84	143	24%	22%	36%	29%
Inpatient and Other acute	15	10	11	36	41%	25%	24%	29%
Substance use + co-occurring	2	2	3	7	29%	29%	25%	27%
Mental health	11	8	8	27	44%	25%	24%	30%
Residential ^c	2	0	1	3	25%	0%	50%	27%
Substance use + co-occurring	1	0	---	1	17%	0%	---	14%
Partial hospitalization	1	1	5	7	11%	8%	38%	21%
Substance use + co-occurring	0	0	2	2	---	0%	100%	67%
Mental health	1	1	3	5	14%	9%	27%	17%
Intensive outpatient and Extended day treatment	9	3	31	43	26%	7%	31%	25%
Substance use + co-occurring	0	0	3	3	0%	0%	60%	38%
Mental health	7	3	16	26	29%	13%	30%	26%
Outpatient counseling	3	13	53	69	11%	25%	51%	38%
Substance use + co-occurring	0	---	5	5	0%	---	100%	83%
Mental health	3	13	48	64	13%	27%	48%	38%
Outpatient substance treatment ^d	0	---	0	0	0%	---	0%	0%
Substance use + co-occurring	0	---	0	0	0%	---	0%	0%
Mental health	---	---	---	---	---	---	---	---
Home-based models	14	3	9	26	23%	19%	24%	23%
Substance use + co-occurring	5	0	---	5	56%	0%	---	50%
Mental health	9	3	9	21	18%	20%	24%	21%

^a Treatment options for which there no commercial insurance equivalents or that are not aimed at assisting people with substance use or co-occurring disorders, such as types of congregate care, have been excluded from this and subsequent charts.

^b The Substance use + co-occurring and Mental health categories frequently do not sum to the overall number shown, here and in the shaded rows, because the overall number includes requests for which no diagnosis was available.

^c According to BHP, there is no true mental health equivalent of substance use residential treatment.

^d Ambulatory detoxification and methadone maintenance.

Source: PRI staff analysis of BHP data.

There are a couple of interesting features of this table. First, outpatient counseling and the combined category of intensive outpatient and extended day treatment had similarly high appeals volume, but the rate of overturn was somewhat higher for outpatient counseling. Second, across categories, the overturn rate fluctuates somewhat - likely due, at least in part, to very small numbers.

BHP data: Medical necessity denials and appeals. In early December, as part of DSS feedback to a preliminary, partial version of this report, the department provided versions of Tables J-8 and J-9 that included only denials and appeals based on medical necessity (as opposed to administrative reasons, such as a person's BHP coverage not being in effect). The analysis was completed by state agency and/or ValueOptions personnel, not by the program review committee staff. The tables (J-10 and J-11) are shown below.

Table J-10. Number and Estimated Maximum Percent of BHP Youth (Ages 12-25) Denials Based on Medical Necessity Appealed, for Treatment Categories Relevant to Substance Use, Overall and By Diagnosis, 2009-2011^a								
	<i>Number of Appeals</i>				<i>Est. Max. Percent of Denials Appealed</i>			
	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2009-2011</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2009-2011</i>
All categories ^b	20	11	12	43	37%	22%	20%	26%
Substance use + co-occurring	7	1	5	13	58%	6%	19%	24%
Mental health	13	9	7	29	32%	26%	21%	27%
Inpatient and Other acute	9	10	11	30	23%	24%	24%	24%
Substance use + co-occurring	2	1	4	7	50%	8%	27%	22%
Mental health	7	9	7	23	19%	31%	23%	24%
Residential ^c	5	1	---	6	125%	---	---	100%
Substance use + co-occurring	2	---	---	2	75%	33%	0%	54%
Partial hospitalization	---	---	---	---	0%	0%	0%	0%
Substance use + co-occurring	---	---	---	---	---	0%	0%	0%
Mental health	---	---	---	---	---	---	---	---
Intensive outpatient and Extended day treatment	2	---	1	3	33%	0%	11%	19%
Substance use + co-occurring	2	---	1	3	33%	0%	11%	19%
Mental health	---	---	---	---	---	---	---	---
Outpatient substance treatment ^d	---	---	---	---	---	---	---	---
Home-based models	4	---	---	4	133%	0%	---	80%
Substance use + co-occurring	1	---	---	1	---	---	---	---
Mental health	3	---	---	3	100%	0%	---	60%

Note: This table was received by the program review committee staff just before the report was due. There was insufficient time to clarify and verify certain data elements.

^a Treatment options for which there no commercial insurance equivalents or that are not aimed at assisting people with substance use or co-occurring disorders, such as types of congregate care, have been excluded from this and subsequent charts.

^b The Substance use + co-occurring and Mental health categories frequently do not sum to the overall number shown, here and in the shaded rows, because the overall number includes requests with no diagnosis given.

^c According to BHP, there is no true mental health equivalent of substance use residential treatment.

^d Ambulatory detoxification and methadone maintenance.

Source: DSS.

Table J-11. Number and Estimated Percent of BHP Youth (Ages 12-25) Appeals of Denials Based on Medical Necessity, Resulting in Overturn, for Treatment Categories Relevant to Substance Use, Overall and By Diagnosis, 2009-2011^a

	<i>Number of Overturns</i>				<i>Est. Percent of Appeals Overturned</i>			
	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2009-2011</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2009-2011</i>
All categories ^b	7	4	3	14	35%	36%	25%	33%
Substance use + co-occurring	1	---	1	2	14%	0%	20%	15%
Mental health	6	4	2	12	46%	44%	29%	41%
Inpatient and Other acute	4	4	3	11	44%	40%	27%	37%
Substance use + co-occurring	1	---	1	2	50%	0%	25%	29%
Mental health	3	4	2	9	43%	44%	29%	39%
Residential ^c	2	---	---	2	40%	0%	---	33%
Substance use + co-occurring	---	---	---	---	0%	---	---	0%
Partial hospitalization	---	---	---	---	---	---	---	---
Intensive outpatient and Extended day treatment	---	---	---	---	0%	---	0%	0%
Substance use + co-occurring	---	---	---	---	0%	---	0%	0%
Outpatient substance treatment ^d	---	---	---	---	---	---	---	---
Home-based models	1	---	---	1	25%	---	---	25%
Substance use + co-occurring	---	---	---	---	0%	---	---	0%
Mental health	1	---	---	1	33%	---	---	33%

Note: This table was received by the program review committee staff just before the report was due. There was insufficient time to clarify and verify certain data elements.

^a Treatment options for which there no commercial insurance equivalents or that are not aimed at assisting people with substance use or co-occurring disorders, such as types of congregate care, have been excluded from this and subsequent charts.

^b The Substance use + co-occurring and Mental health categories frequently do not sum to the overall number shown, here and in the shaded rows, because the overall number includes requests for which no diagnosis was available.

^c According to BHP, there is no true mental health equivalent of substance use residential treatment.

^d Ambulatory detoxification and methadone maintenance.

Source: DSS.

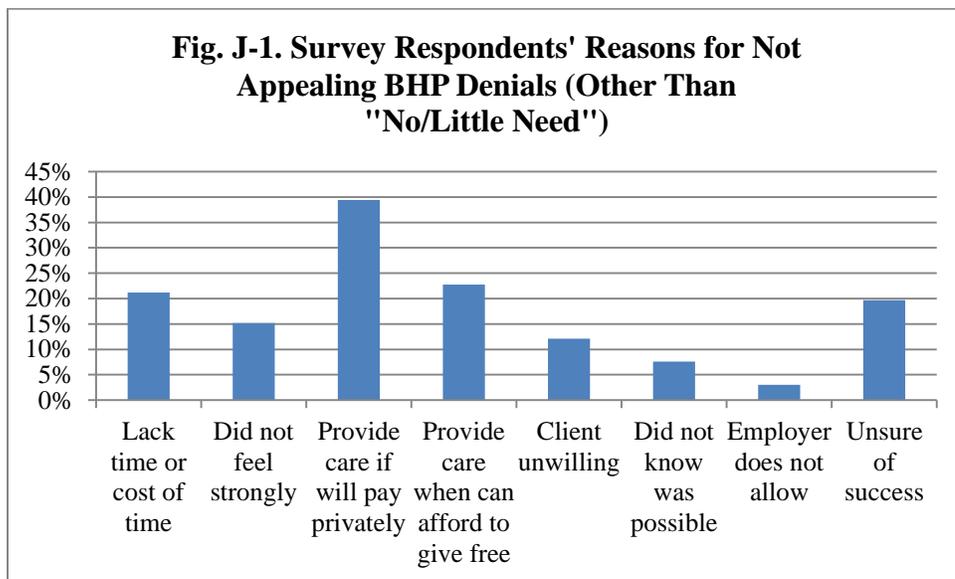
HUSKY D residential treatment. Because there were no denials, there is no appeals data to present.

Survey data. Nearly two-thirds (63 percent) of survey respondents were employed at a place that accepts Medicaid. Of those, under one-fifth (18 percent) have appealed a denial of coverage within the last year.⁶⁹

Reasons for low BHP appeals rate. Survey data provide some additional information and illumination, from the treating practitioner's perspective. Half (51 percent) of responding

⁶⁹ Of the 420 respondents to the BHP acceptance question, 266 were affirmative. Of those 266, ten did not respond to the question about recently filing a BHP appeal.

practitioners indicated they had not always filed an appeal because few, if any, of their requests had been turned down. Other practitioners gave a range of reasons, shown in the chart below.⁷⁰



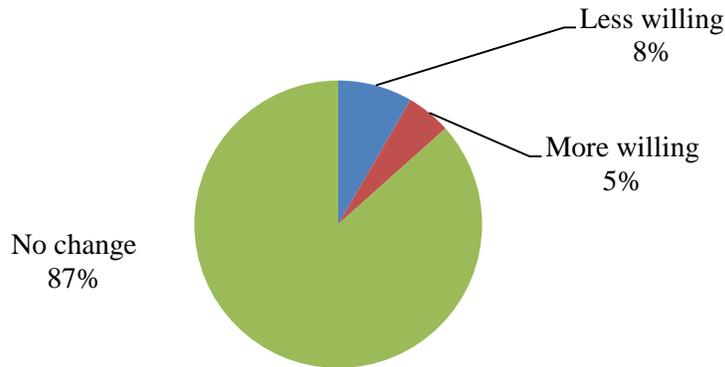
The most common reason among this set of respondents was that they would give care if the person would pay privately. Given that the majority of these clients are Medicaid-eligible (except for two small groups, Charter Oak and DCF Limited Benefit), and therefore low-income, the program review committee was puzzled by the volume of this response. It may reflect the official policy of an employer, more than what staff believes is likely or possible.

Another survey question asked whether practitioners' willingness to file a BHP appeal had changed within the last two years, and if it had, to describe how and why. The aim of the question was to understand whether there had been any recent trends in this area.

The vast majority of respondents stated their willingness to file a BHP appeal has not changed recently, as depicted in Figure J-2. A slightly higher percentage said they were less willing to file, compared to more willing, but neither group rose to even 10 percent of total responses.

⁷⁰ There were 200 respondents to the question: "IF you did not always file for an appeal, why not?" Respondents were allowed to select multiple options; hence, the chart percentages do not sum to 100. The chart is limited to those 66 respondents who did not select the "No need..." option (either solely or in combination with other options).

Fig. J-2. Survey Responses to Whether Willingness to File an Internal BHP Appeal Has Changed Recently



The survey requested that respondents describe in their own words why their willingness had changed, if applicable. Program review committee staff reviewed and then categorized these explanations. Because the number of respondents was extremely small, the chart is presented for illustrative purposes only; the program review committee does not feel comfortable commenting on most of the data. It is noteworthy, however, that as with commercial insurance, the time needed to support and pursue an appeal is a major factor in providers' decision-making.

Table J-12. Reasons for Change in Willingness to File An Internal Appeal Among Survey Respondents

	<i>Less Willing</i> n=12	<i>More Willing</i> n=5
Insurers		
Inflexible / limiting coverage	8%	0%
Make incorrect judgment / not proper judge	8%	40%
More flexibility / authorizations	8%	0%
Past appeals experiences		
Little or no success	33%	0%
Found persistence leads to success	0%	0%
Resources		
Time required to support, pursue appeal	67%	0%
Time to support, pursue appeal is unpaid	17%	0%
Change in knowledge / staff to assist in appeal	0%	60%
Notes: These responses are for those survey respondents who indicated their willingness to file an internal appeal had changed in the last two years and provided an explanation of the reasons for the change. Percentages do not sum to 100 because some individuals provided multiple reasons. Source: PRI staff analysis of practitioner survey data.		

External Appeal: Fair Hearing

Accepted applications. The fair hearing process is rarely sought by BHP youth enrollees (or their parents) who have received a coverage denial (for medical necessity or other reasons).

Only eight denials were scheduled (through an application) for a fair hearing in the last five calendar years (2007 through 2011) for prospective and concurrent review denials. The applications were mainly for inpatient psychiatric care (75 percent), with one each regarding long-term (six to nine months) congregate care for DCF-involved minors and psychiatric testing. None were for HUSKY D residential treatment.

There were four initial retrospective review denials, over the same five-year period. Of these, two were appealed. One was overturned at internal appeal, while the other was scheduled for a fair hearing.

Results. Of the eight applications for fair hearings on prospective and concurrent treatment denials, six were withdrawn. DSS reported that nearly all withdrawals were made by members (not by ValueOptions or a state agency, both of which may overturn the decision before the fair hearing occurs), as mentioned above.

Among the three fair hearings held – two on prospective or concurrent denials, and one on retrospective denial – one (the retrospective one, which occurred in 2007) found for the enrollee.

Table J-13. BHP Fair Hearing Decisions, 2007-2011					
<i>Review Timing</i>	<i># Hearings Scheduled</i>	<i># Hearing Requests Withdrawn</i>	<i>Of Completed Fair Hearings:</i>		
			<i># Completed</i>	<i># for Enrollee</i>	<i>% for Enrollee</i>
Prospective and Concurrent	8	6	2	0	0%
Retrospective	1	0	1	1	100%
Total	9	6	3	1	33%

Source: PRI staff review of BHP data.

Utilization Review Consumer Assistance

Complaints

Connecticut Insurance Department (CID). The CID's Consumer Affairs Unit accepts and investigates any complaints and questions, from enrollees or providers.

Complaint methods. Complaints may be made via e-mail, fax, or letter, or directly into the online system available on the department's website. Those who choose to phone in a complaint are urged to submit their grievance in writing; if they do not, then the department does not investigate it. In order to be investigated, the complaint must contain the person's name, member identification number, carrier, and a description of the problem.

The program review committee considered recommending CID accept complaints over the telephone, since the agency already offers a "Consumer Helpline." The insurance department reported, however, that few callers are ready with the full extent of information necessary for CID investigation. In addition, it would take substantially increased staffing to both follow up on missing information and record information received by telephone. Finally, of four nearby states, only one (New York) accepts complaints on the telephone, according to committee staff research.

Processing. If insufficient basic information has been provided in a written complaint, then CID staff attempts to acquire it by contacting the complainant – usually by telephone first, then e-mail if still necessary. If no response has been received within ten days, then the examiner sends a letter stating that the file has been closed for lack of information, but will be re-opened if the missing components are provided.

The relevant unit supervisor – for example, the health supervisor – then determines and codes the complaint's complexity, which corresponds with the maximum timeframe for closing the issue. Simple complaints are to be finished within 30 calendar days; moderately difficult issues, within 45; and complex grievances – which are uncommon – within 60 days. The supervisor assigns each complaint to a worker. Four full-time staff handle complaint processing for the health unit of Consumer Affairs.

The assigned staff person contacts the carrier, via e-mail, within five days of complaint receipt. CID provides the carrier with the basic information, asks for any records related to the complaint, and requests the carrier provide its interpretation of the situation. If the complaint is related to utilization review, CID also requests the name of the utilization review company involved, which will be recorded in the complaint database for use during Market Conduct reviews (described below). The carrier has ten days to respond.

If the complaint is about a utilization review denial, the insurer will tell CID at what stage the complaint is in the review and appeals process (e.g., whether an internal appeal has been filed). CID staff stated that occasionally the insurer will report that an appeal request had not

been received, but that there has been enough information provided for the complaint to be considered one. When that happens, the insurer contacts the enrollee directly and CID keeps the complaint open until it learns whether the appeal was successful.

Unlike the healthcare advocate and attorney general offices, CID does not offer consumer advocacy within the appeals (or initial determination) process. The department views its role as one of providing guidance so the enrollee understands rights and how to exercise them. However, if a complaint has been received about a utilization review denial, CID forwards a copy to the Office of the Healthcare Advocate, so staff from that office - who generally have either legal or health care training - may follow up with the person to offer assistance, parallel to CID's handling of the complaint.

When reviewing complaints, CID compares the insurer response with the complaint to verify that the insurer followed the appropriate process and notification requirements, and if it involves a denial, that the denial was for a reason that makes sense or was justified. The staff may ask for the insurance policy to help it make the determination. Staff then assess what they believe the issue is and what should happen next. They summarize this information in the complaint's case file before creating a letter to the complainant.

Staff use letter templates that thank the complainant for contacting the department, summarize the carrier's response and the CID's assessment, and lay out the next steps (if any) for the complainant to take. Often the insurer's response to CID is enclosed with the department's response. Possible results of a complaint specific to utilization review are described in the chart below. (Many CID complaints are from providers about billing issues or are simply questions from consumers about what a policy covers.)

Table K-1. Examples of CID Utilization Review Complaints: Issue, CID Determination, and Possible Consumer Results		
<i>Issue</i>	<i>CID learns / determines</i>	<i>Consumer might receive</i>
Utilization review denial for medical necessity or experimental treatment	What stage process is at (e.g., eligible for internal or external appeal; or not)	<ul style="list-style-type: none"> • Information: whether eligible for appeal; and/or • Internal appeal initiation; and/or • External review (i.e., appeal) guide, if applicable
Utilization review denial because request/treatment not covered	If request/treatment is covered under the policy	<ul style="list-style-type: none"> • Verification of insurer decision as allowable; or • Coverage – usually if insurer staff made a mistake at some point, or if is clearly required by policy
Utilization review decision not received within required timeframe	If that was true, and if so, if it is part of a larger issue at utilization review company	<ul style="list-style-type: none"> • Verification (or not) of insurer violation of law, and notice that is (or not) eligible for external review
Source: PRI staff communication with CID.		

The CID staff supervisor approves the closing of most cases, including a comprehensive review of the coding of the case in the system. The supervisor reviews the case in-depth if it involved recovered money for the consumer or provider, uncovered a violation of state law, or was handled by a new employee.

The complaint data are reported to the National Association of Insurance Commissioners (NAIC) daily. NAIC aggregates and reviews the data for trends across states. Consequently, the major complaint coding categories and options are determined by NAIC, with some sub-coding at the discretion of the state insurance departments. Program review committee staff requested and CID provided some complaint data relevant to the study.

Behavioral health complaints have been a very small percentage of all CID complaints, at less than three percent for each of the last three years. The number of behavioral health complaints rose in 2010, but then dropped back to approximately the 2009 level. The share of complaints about behavioral health increased in 2010 and remained at the elevated level in 2011.

Table K-2. Health Insurance Consumer Complaints Received by CID, 2009-2011								
	2009		2010		2011		Total	
All complaints	2,334	100%	2,051	100%	1,956	100%	5,787	100%
Behavioral health	40	1.7%	52	2.5%	38	2.7%	130	2.2%
Medical/Surgical	2,294	98.3%	1,999	97.5%	1,364	97.3%	5,657	97.8%
Utilization review complaints	147	100%	131	100%	116	100%	394	100%
Behavioral health	16	10.9%	20	15.3%	11	9.5%	47	11.9%
Medical/Surgical	131	89.1%	111	84.7%	105	90.5%	347	88.1%
By complaint type, percentage that were utilization review complaints								
Overall	147/2,334	6.3%	131/2,051	6.4%	116/1,956	8.3%	394/5,787	6.8%
Behavioral health	16/40	40.0%	20/52	38.5%	11/38	28.9%	47/130	36.2%
Medical/Surgical	131/2,294	5.7%	111/1,999	5.6%	105/1,364	7.7%	347/5,657	6.1%
Note: These data are for the health insurance complaints received by CID, excluding complaints related to disability insurance and other categories not of interest to this study. Therefore, they do not represent the whole universe of accident and health complaints registered with the department.								
Source: PRI staff analysis of CID data.								

A substantial portion of behavioral health complaints that were received – between 40 and 29 percent annually – were about utilization review. (Other potential reasons for complaints are things like policy cancellation, improper representation, or difficulty getting coverage for a mandated benefit.) In contrast, under 8 percent of medical/surgical complaints annually were about utilization review. This discrepancy leads to behavioral health complaints accounting for a disproportionately large share of utilization review complaints, given the overall complaint distribution between the two types of health care. In the view of CID, this fact is not indicative of a problem. They believe that behavioral health treatment is more subjective and therefore there is more room for providers and enrollees to question utilization review decisions.

Office of the Healthcare Advocate (OHA). Enrollees seeking assistance or wishing to lodge complaints can contact OHA by phone, e-mail, fax, or letter. Similarly to CID complaints, each is assigned to a staff person in charge of resolving the matter.

Staff attempt to contact the complainant within one day of assignment. If the case is urgent, contact occurs as soon as the complaint is read. If the complaint is about a utilization review care denial, OHA offers advocacy assistance to the enrollee or provider, as described below.

A database of complaints is kept but there are a few problems that make it difficult to accurately interpret information for this report’s purposes. OHA switched its data system in 2011 and continues to refine the information that is collected. In addition, there are gaps in data entry.

Consequently, the information presented below is included to give a sense of the specific health insurance coverage problems for which enrollees have sought OHA assistance. The table shows that utilization review accounts for 42 percent of specific issues brought to the healthcare advocate office’s attention.

Table K-3. Types of Insurer Complaints Made to OHA, 2011 and 2009-2011		
<i>Type</i>	<i>2011</i>	<i>2009-11 %</i>
Billing / claim handling	383	19%
Care access / quality	57	3%
Customer service	57	3%
Policy / benefit	272	14%
Utilization review denial	823	42%
Other specific reason	380	19%
Total	1,972	19%
Source: PRI staff analysis of OHA data.		

These complaints to OHA span the spectrum of types of care. The data, again, have some limitations - both those mentioned above, and a lack of differentiation in two key ways. First, care settings or care categories - such as hospital care and lab work - are referenced generally (not, for example, a hospital stay involving a pulmonology procedure). Second, there is no distinction made between mental health and substance use treatment.

Despite the limitations of the data, it is clear that OHA receives many complaints about behavioral health care. Behavioral health complaints were the largest single category in each of the last three years, annually making up a substantial chunk of total complaints. The three-year average percentage for 2009 through 2011 was 18 percent when care settings are included (n= 4,254) and 25 percent when those are excluded (n=3,203).

Office of the Attorney General (AG). The Health Care Advocacy Unit accepts consumer complaints through telephone calls, letters, and e-mail. The equivalent of two full-time staff is dedicated to addressing these health insurance grievances.

The AG staff call the complainant within one week (if the complaint was not made via telephone) to learn whether other state agencies have been notified or involved in the matter. If so, then they ask the person where the process is (e.g., just received initial denial of coverage) and talk with the other agencies’ personnel to figure out how or whether to coordinate in the consumer assistance work.

The unit keeps a database of the complaints received and work associated with each. The database, however, is kept on an outdated platform, and cases are not coded according to type of medical service sought. Consequently, data specific to substance use coverage are unavailable. Staff estimate that less than five percent of health insurance complaints are about substance use coverage.

The number of all health insurance complaints received by the office in recent years is provided in Table K-4. The office is unsure why its complaint volume has been declining.

Table K-4. Health Insurance Consumer Complaints Received by the Office of the Attorney General, 2009-2011.	
<i>Year</i>	<i># Complaints</i>
2009	752
2010	703
2011	446
Source: Office of the Attorney General	

Casework

Complaints received by OHA or the AG can turn into advocacy on behalf of the consumer (or the provider). Specific to utilization review, when a person contacts either office complaining of a coverage denial, staff will offer to assist the person in appeal efforts, as described below. OHA’s staff for these matters is substantially larger, although the AG has been offering this advocacy assistance for a slightly longer period of time (since 1998, versus 1999). In addition to this state-funded assistance, consumers may seek help from a private lawyer or business, including legal aid societies.

Office of the Healthcare Advocate. The Healthcare Advocate’s office has 12 full-time equivalent case managers, to handle consumer and provider assistance. (The office recently received additional state funding, as well as another federal grant.) Each case manager has at least a master’s degree and generally handles about 30 consumer assistance cases at a time. The case managers tend to develop specialty areas, and largely are assigned cases in a particular area (e.g., behavioral health).

The level of assistance provided varies depending on the complainant’s expressed wishes and abilities. It can range from a contact or two, during which the OHA staff person will answer questions and offer guidance (i.e., be a coach), to the case manager taking charge of the appeals. Just over half (54 percent) the utilization review and coverage calls received result in the case manager directly leading or intervening, according to OHA data from 2009 through 2011.

Coaching generally involves discrete questions or tasks. For example, the case manager may give feedback on the person's appeal letter and tell them the importance of submitting medical records to support the request.

If someone is led by OHA, a case manager will spearhead the process through writing the appeal letters, representing or supporting the person during a telephone or in-person internal appeal, and ensuring supporting documentation is submitted by all relevant providers and parties. The documentation ideally includes:

- an in-depth letter from the enrollee (or their parent);
- medical records for at least the last few years;
- provider letters supporting the request; and
- a memo from OHA summarizing the case facts and supporting the request.

The office staff reported that they try to gather and submit all supporting documentation as soon as they become involved. If they were involved at the internal appeal level and the case proceeds to external review, then there is little more to be done beyond submit the package of materials to the review organization, via the insurance department.

OHA personnel noted to program review staff that even when they lead the process, they try to teach the enrollee how to advocate for themselves, so they are better equipped if and when future problems arise.

Office of the Attorney General. When an enrollee complains about a coverage denial based on medical necessity, the staff will attempt to learn if OHA has been notified or involved. If so, the two offices' staff communicate to ensure that work is not duplicated; they may assist the consumer together or give the case to one office. The attorney general's staff offers substantially similar assistance as the healthcare advocate's. They may work with the enrollee to:

- craft an appeal or external review request;
- gather any supporting documentation; and
- assist with the effort in any other way – for example, by helping the enrollee prepare for and present during a telephone or in-person internal appeal effort.

If the timeframe for internal or external appeal has expired, the staff may write the insurer, asking for voluntary reconsideration.

Due to the outdated platform on which information regarding complaints and subsequent casework is kept, the office could not produce data showing the volume or results of its efforts.

Websites

Program review committee staff visited the OHA and CID websites to understand what electronic resources may be available to the public.

Office of the Healthcare Advocate. Web information can provide timely assistance that demands fewer resources than typical OHA case work.

For much of this study, the website has offered some valuable information on utilization review: how to write a complaint to a plan, what an appeal letter should include, and information on the CID external review process.

There were, however, some shortcomings. First, the website stated that sample appeal letters were coming soon – in January 2012. The program review committee believes sample appeal letters would be quite helpful. Second, various pieces of information were out of date. For example, the external review page does not explain that external review often is now available to enrollees in plans other than fully-insured, while the “Three Step Complaint Process” page has incorrect internal and external appeal filing deadlines. Third, the site directed a person undertaking an appeal to collect a letter from the provider. While a letter may be helpful, additional medical records may be crucial. Fourth, the relevant information was not easy to find; it was available only through the “Problems” link, which was the seventh option on the left-side vertical grouping. Given that utilization review denials are the second-largest portion of OHA’s complaints,⁷¹ a prominent link on the home page that says, “Coverage denial assistance” or something similar likely is warranted.

Connecticut Insurance Department. CID’s website contains some limited healthcare utilization review information and assistance. The “Consumer Services – Health Insurance...” link provides assistance in locating different types of insurance plans, information on selected topics including external review, and a list of other resources. External review information is also available through a link on the “Complaint / Question” webpage (which is, itself, a prominently link on the CID home page). As noted in Section IV, neither location provides information on utilization review or internal appeals requirements - or a highly visible link to OHA's website.⁷²

⁷¹ 2012 Fiscal Year Activities, Office of the Healthcare Advocate. Accessed September 27, 2012 at: http://www.ct.gov/oha/lib/oha/documents/combined_fiscal_year_12_report_with_2011_annual_report.pdf.

⁷² A link to OHA is the 41st of 43 links on the "Health Insurance Consumer Information" page, accessed through "Health Insurance - More Helpful Resources: Other Connecticut Health Insurance Programs."

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Utilization Review Oversight

The Connecticut Insurance Department (CID) checks insurer compliance with utilization review laws for the state’s fully-insured plans in several ways, discussed below (in no particular order). In addition, the insurance department sometimes receives complaints from the healthcare advocate and attorney general, requesting they look into potential violations.

When a method other than a regularly scheduled review – 1 and 2 below, or as noted above – indicates an apparent or likely problem, the insurance department can initiate a Market Conduct review (called an “examination”). These reviews – other than those regularly scheduled – are considered preliminary insurance department action against a company, and must be reported to the National Association of Insurance Commissioners. Therefore, if there is not strong data supporting the likelihood of a problem, the insurance department will choose to informally ask a company questions, rather than launching an examination, or to refrain from any steps.

If an insurance department examination uncovers malfeasance by a utilization review company, a hearing may be held and penalties levied. CID reports that hearings are rare; agreements about penalties are usually reached. The department may:

- impose civil penalties, up to certain limits;⁷³
- suspend or revoke the company’s license, if it knowingly violated state law; and/or
- require repayment of its expenses in investigating and deciding punishment.⁷⁴

The five methods of CID insurer monitoring are described below.

1. Consumer complaint trends: The health insurance supervisor within the Consumer Affairs unit at CID reviews all incoming complaints and takes note when there appears to be many complaints about a topic or an insurer. When that happens, one person is assigned to handle all future similar complaints so the unit more easily may determine if there is a problem. Furthermore, the whole unit has biweekly meetings, when apparent complaint trends are discussed. If a trend develops and the unit believes it is concerning, CID staff meet to determine future action, such as asking the insurer questions or referring the matter to the Market Conduct unit for possible investigation. CID reported that they have not detected any trends of concern relevant to this study - for example, a high number of complaints regarding denials for residential treatment for substance use.

⁷³ If the company did not know it was violating state law, the payment is limited to \$1,500 per act or violation, with an aggregate cap of \$15,000. If the company knowingly violated the law – or, reasonably should have known – the penalty limits are \$7,500 and \$75,000, respectively.

⁷⁴ C.G.S. Sec. 38a-591k

Complaints that, upon CID research, indicate confirmed or likely law violations are coded as such by department staff. For each accident and health insurer, the department annually divides the number of these complaints by the insurer's premium, to calculate a "complaint ratio." The ratio for each company is given, in both alphabetical and numeric rankings; there is also a list of companies for whom no such complaints were received. This document is available through the "Reports" tab of the insurance department's website, or through an active link in the Managed Care Regulation report described below.

States' consumer complaint data are collected and reviewed at the national level, as described Appendix K. Insurance department staff in any one state may review the data submitted by another. CID staff report that there have been a few multi-state examinations that resulted from review of national data, but none specific to health insurance. These examinations are led by a state or a vendor that collaborates with all the applicable states.

2. Denial and consumer-overturn rates: Carriers annually report data on utilization review requests, denials, and internal appeals results for requests both overall and specific to certain areas (e.g., inpatient admissions, outpatient services, and extensions of stay), for fully-insured plans. This information (along with other data) is presented among two statutorily required yearly CID reports: Consumer Report Card on Health Insurance Carriers in Connecticut and Managed Care Regulation. These reports were available through the "Reports" tab of the insurance department's website.

Program review committee staff reviewed the Consumer Report Card data, which are more extensive than that in the Managed Care Regulation report, for 2010 and 2011, which relied on data for 2009 and 2010, respectively. The report card presents behavioral health care utilization review data in raw numbers; committee staff calculated certain percentages and, for data in the 2011 report, used a chi-square test for statistical significance. The resulting analysis, presented in the table below, shows that particular plans are clear outliers for percentages of initial denials and ultimate request success rates by levels of care.

- Inpatient requests were denied 19 and 36 percent of the time for two carriers, but 0 to 3 percent of the time for the other four carriers;
- Outpatient initiation requests were denied 13 percent of the time for one carrier, but 2 to 8 percent for the other five carriers; and
- Extensions of stay were denied 13 percent of the time for two carriers, but 1 to 4 percent of the time for other four carriers.

Each of these differences reached the level of statistical significance ($p < 0.01$), meaning it is highly unlikely a difference that large is due to chance.

Table L-1. Behavioral Health Utilization Review: Percent of Requests Initially Denied, and Percent of Initial Requests Filled, For Enrollees of Fully-Insured HMO Plans, 2011			
	<i>Number of Requests</i>	<i>Percent of Requests Initially Denied (full or partial)</i>	<i>Percent of Initial Requests Filled (initial success or internal appeal success)</i>
Inpatient			
Aetna Health	39	36%**	69%
Anthem BC-BS	600	19%**	82%**
CIGNA	344	3%	98%
ConnectiCare	1,071	1%	99%
Health Net	321	0%	100%
Oxford	144	3%	97%
<i>Overall</i>	<i>2,519</i>	<i>6%</i>	<i>94%</i>
Outpatient			
Aetna Health	333	8%**	92%
Anthem BC-BS	3,863	13%**	88%**
CIGNA	123	5%	97%
ConnectiCare	6,244	3%	97%
Health Net	502	2%	98%
Oxford	188	2%	98%
<i>Overall</i>	<i>11,253</i>	<i>6%</i>	<i>94%</i>
Extensions of Stay			
Aetna Health	0	---	---
Anthem BC-BS	1,086	13%**	88%*
CIGNA	157	4%	96%
ConnectiCare	712	13%**	88%*
Health Net	341	1%	99%
Oxford	87	2%	98%
<i>Overall</i>	<i>2,383</i>	<i>10%</i>	<i>91%</i>
Notes: "Procedures" not included in this table, since only two of the insurers reported Procedures requests (and those were no more than a dozen each). "Percent of Initial Requests Filled" does not include results of the external review process. There have been changes to the plan landscape: Health Net is no longer issuing fully-insured HMO plans, and Oxford has become part of United.			
**p<0.01, when compared to the sum of all other insurers and the total sum			
*p<0.01, when compared to the sum of all other insurers except Anthem and ConnectiCare			
Source: PRI staff analysis of 2011 CID Consumer Report Card data (p. 32)			

A single carrier was an outlier in each case above. This carrier's internal appeals overturn rate for all types of care also was substantially higher than other carriers' rates (65.9 percent, compared to 21.4 to 46.7 percent for other insurers). CID reported that it observed this

overturn rate difference and informally asked the carrier's staff about the behavioral health denial rate.

3. Licensure and annual survey of utilization review companies: Public Act 91-305 first established utilization review company licensure requirements, internal processes and appeals procedures, and sanctions.

The Connecticut Insurance Department issues and annually renews licensure of utilization review companies that conduct reviews for fully insured plans issued in the state. The department's Life and Health division reviews these applications for compliance with state and federal laws.

Minimum licensure requirements are set out in statute: the payment of a \$3,000 licensure fee, and the submission of a request that includes the company's name, contact information, and business hours.⁷⁵ The actual license application also checks for, among other things, the utilization review company's ability to comply with various aspects of utilization review law regarding:

- the employment of licensed practitioners;
- protocols;
- timeframes; and
- decision notice requirements.

The application also asks about sanctions – such as fines or licensure loss – received in other states; CID staff report that no company has yet been denied a license on that basis. Only companies performing utilization review for Connecticut fully-insured plans must be licensed.

Fifty-nine utilization review companies held licenses in 2011. The 2011 public act changed the types of utilization review reporting required and consequently the insurance department no longer knows which companies conduct reviews specifically for mental health and substance abuse. In 2010, however, there were 113 licensed utilization review companies and 38 of those (33.6 percent) conducted reviews for behavioral health.

The 2011 legislation also narrowed the types of utilization review companies required to be licensed to only those that conduct reviews for fully-insured health benefit plans, to comply with the ACA.⁷⁶ Six health maintenance organizations offer fully-insured health plans in Connecticut; their behavioral health care utilization review arrangements are described in the table below.⁷⁷ The Connecticut Medicaid behavioral health program's administrative services organization (ASO), ValueOptions, also is licensed as a utilization reviewer.

⁷⁵ C.G.S. Sec. 38a-591j

⁷⁶ Previously all companies conducting utilization reviews – including reviews for self-funded and other non-fully-insured plans – were required to be licensed by the Connecticut Insurance Department.

⁷⁷ One of the six, HealthNet, no longer is issuing new fully-insured policies in Connecticut, so it is excluded from Table L-2.

Table L-2. Connecticut Fully Insured Plan Carriers' Behavioral Health Utilization Review Arrangements	
<i>Carrier</i>	<i>Utilization Review</i>
Aetna	In-house
Anthem BC-BS	In-house
CIGNA	In-house
ConnectiCare	Optum (affiliated with United Behavioral Health)
United / Oxford	United Behavioral Health
Source: PRI staff conversation with plan staff, August 2012.	

Other licensed utilization review companies conduct reviews for specialties like podiatry, chiropractic, prescription drugs, and lab work, according to the Connecticut Insurance Department.

Licensure must be renewed annually through submission of a brief application and a \$3,000 fee. In addition, each year the utilization review company must complete a “survey.” The survey asks the company to provide a variety of procedural information and data, including: protocols used; numbers of complaints received either directly or from CID; numbers of requests, denials and appeal requests; number of violations of various timeframes; and sample copies of denial letters.

The Market Conduct unit’s four staff dedicated to health insurance⁷⁸ review the survey information provided and identify outliers, who then receive a more in-depth review (but not an “examination”). At CID’s request, the utilization review company shares a listing of all determinations made within the year (or other time period).

The department staff then uses statistical software to select a random sampling of cases – including requests that resulted in initial approvals, denials, and appeals – and asks the company for all documentation related to the requests. The unit staff checks the company’s compliance with the law: proper procedures were followed, timelines met, and notification letters contained required language. The staff are not reviewing whether the decision, itself, was appropriate. The survey also involves a review of each complaint. If the effort detects violations, penalties can result and a "corrective action plan" must be submitted to CID.

The unit manager estimated to program review staff that about two-thirds of the companies involved in a comprehensive review stemming from the annual survey receive a fine or other sanction. In 2011, the annual survey effort resulted in fines to 11 of the 60 licensed utilization review companies (18.3 percent). The fines ranged from \$1,500 to \$8,500, and totaled \$52,000 across companies. The fines were for the following violations:

- untimely approval, denial, and/or appeal decisions (nine companies);
- inaccurate external appeal language (seven companies);
- appeal language not in bold font (three companies);
- inaccurate statistics (all 11 companies); and

⁷⁸ Five additional Market Conduct staff are assigned to other types of insurance; one person manages the whole unit.

- lack of sufficient documentation for regulatory review (four companies).

As noted previously, the health maintenance organizations that offer fully-insured health plans (the type under the purview of the CID and its Market Conduct division) conduct their own behavioral health utilization review. Of these plans, the 2011 survey uncovered violations for one of the six. The two companies with the highest-level fine (\$8,500) were both associated with this carrier; one company had violations in all five areas, and the other (its company that offers fully-insured plans) in four of the five.

Statute sets limits on the utilization review company penalties. A company may be fined up to \$1,500 for each act or violation, up to a maximum of \$15,000. CID interprets "act or violation" to be each instance discovered during the course of the survey, which looks at a sampling of requests. However, if a company knew or "reasonably should have known" it was in violation of notification or utilization review timeframe requirements, the penalties are more severe. The amount may be up to \$7,500 apiece – up to a maximum of \$75,000 – or the company's license can be suspended or revoked.⁷⁹

These fine levels have been in place since P.A. 08-178. The previous maximum allowable fines were \$1,000 per act up to a sum of \$5,000. If the company knew or should have known about the violations, the limits were \$5,000 and \$50,000 respectively.

4. Five-year insurer review: Every five years, CID conducts a comprehensive review of every type of insurer issuing plans in Connecticut. The review involves all aspects of the insurer's practices and business (e.g., underwriting, advertising), except financial. These reviews take three to four months in staff time, but can last up to a year from the time the information is requested from the insurer, to the final administrative action (if any). Department staff reported that most reviews result in fines for the insurer, with the size of the overall penalty corresponding to the magnitude of the problems discovered.

For health insurers, the review examines a selection of appeals that were overturned. If a sizeable proportion of overturns appears to not have been the result of additional information considered, then that could signal a problem (e.g., denials made without regard to the request's merits). The CID has not detected this type of problem for behavioral health, although these claims are always part of the review. When Connecticut's parity law was first passed – but not recently – violations of the state's parity law were found, according to CID staff.

5. Complaints from other state offices: The CID sometimes receives complaints from the offices of the attorney general and healthcare advocate. These complaints, if supported to the department's satisfaction, may result in Market Conduct examinations of insurers or utilization review companies. As noted elsewhere in this report, CID has stringent requirements to launch a Market Conduct examination.

When the complaint data or other sources of information indicate there may be a problem with a protocol – either a lack of uniformity across insurers or particular to one carrier – the insurance department acts. CID requests the protocol and asks the relevant department of the

⁷⁹ C.G.S. Sec. 38a-591k

University of Connecticut's medical school to evaluate it, on the department's behalf. As noted in the report's main body, one carrier's behavioral health protocol currently is being reviewed by the medical school's psychiatry department.