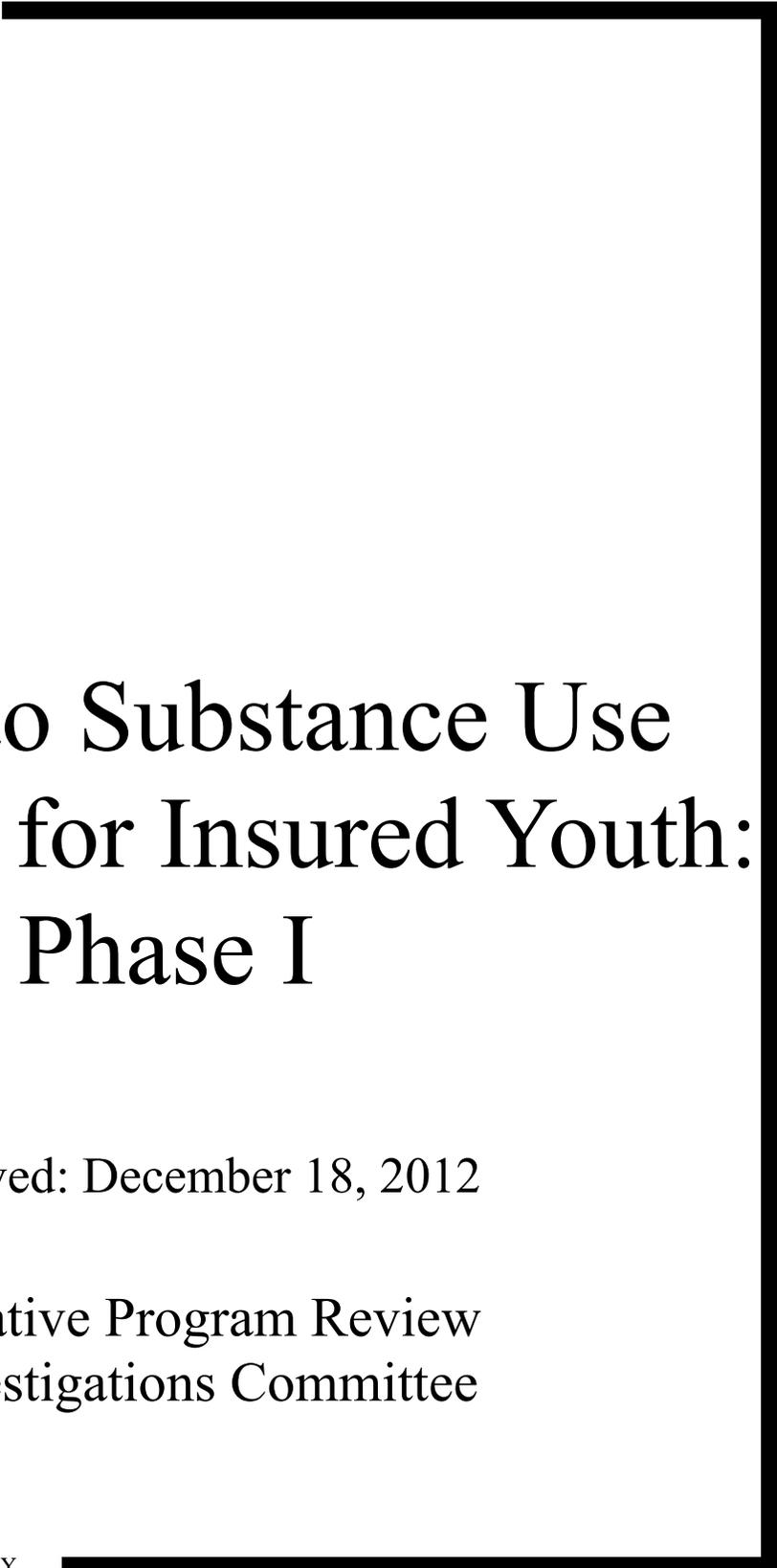


Committee
Report



Access to Substance Use Treatment for Insured Youth: Phase I

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Access to Substance Use Treatment for Insured Youth

Background

In April 2012, the program review committee authorized a study to assess insurer coverage and enrollee utilization of substance use treatment. In addition, the project aims to examine supply and demand for those treatment services. The study is limited to youth ages 12-25 who have private (i.e., commercial) or Medicaid insurance.

In Connecticut, about 8% of youth ages 12-17 and 24% of those ages 18-25 have met the clinical criteria for abuse or dependence on alcohol or an illicit drug, within the past year, according to a recent federal survey. Research estimates indicate a substantial portion of those needing treatment do not receive it, perhaps due, in part, to insurance coverage and capacity issues.

Commercial health plans that are fully insured generally are regulated by the state, while self-insured plans (in which the employer assumes the financial risk of coverage) and Medicaid are subject to federal oversight. Plan coverage of substance use treatment is affected by mental health parity laws at both government levels.

A Connecticut resident with a health plan coverage complaint may seek assistance from the state's insurance department, Office of the Healthcare Advocate, and Office of the Attorney General. If the plan is self-insured or a government plan, certain federal or state agencies may be more appropriate venues for grievances.

This report, which focuses on the insurance aspect of care accessibility, is based on: interviews with staff from multiple state agencies and offices, advocates, treatment providers, and researchers; review of state and federal laws, as well as literature on substance use treatment; health plan and Medicaid data; and practitioner survey results.

A second report, examining treatment services capacity and overarching issues, will be issued in early 2013.

Main Findings

The Connecticut Insurance Department (CID) does not sufficiently oversee behavioral health care coverage. CID does not check that fully-insured plans (the limits of its jurisdiction) comply with all aspects of the federal parity laws. It also does not use data received from the plans to detect and resolve potential problems in how plans determine, through the utilization review process, whether requested behavioral health care is covered in an individual situation.

The state's Medicaid program offers a slightly wider range of substance use treatment options and has higher coverage approval rates, compared to fully-insured commercial plans. The Behavioral Health Partnership (BHP) has in-home treatment options available to some groups. Contrary to some perceptions, the commercial plans do authorize substance use treatment coverage - even at high levels of treatment. However, the 2011 authorization rates are lower than BHP's, and vary among plans and levels. The fully-insured plans' approval rate for residential treatment (73%) is the lowest among the levels of care.

Fully-insured plans are not required to make initial coverage decisions using practitioners and criteria that would be the most appropriate. The practitioner does not need special expertise or to use the manual widely agreed to represent consensus on the necessary level of care and duration of treatment for a particular client.

There are appeals processes available, but most coverage denials are not appealed. Denial notices are not required to indicate that state agency assistance with appeals is free or what types of documentation could help an appeal succeed.

PRI Recommendations

Numerous recommendations have the overall goal of improving insured youth's access to appropriate treatment. This is a critical goal because substance use has tremendous costs to society, families, and individuals. It can and does result in direct and indirect cost-shifting from the private to public sector.

The report's recommendations, taken together, aim to accomplish 3 goals:

1. **Improve CID oversight**, by instituting a new check of plan compliance with the federal parity law and requiring the plans' data be used to actively monitor utilization review results
2. **Require substance use treatment coverage decisions be made more quickly and appropriately**, by having stricter requirements about the decision timeframe and methods
3. **Make the appeals process more user-friendly**, by being explicit about the availability of free state office assistance and how to support an appeal

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

Access to Substance Use Treatment for Insured Youth

In Connecticut, about one in twelve adolescents (ages 12 through 17) and one in four young adults (18 through 25) have abused or become dependent on alcohol or an illicit drug within the past year, according to a recent estimate.¹ These youth, who are said to have a substance use disorder, can enter into a range of treatments and settings. In recent years, however, nationally only about 10 percent of adolescents and less than 7 percent of all people with a substance use disorder have received treatment.²

There are many potential reasons for this treatment gap, including a person's denial that a problem exists, under-detection of the disorder by healthcare professionals, the social stigma surrounding substance use, and difficulty accessing care even when someone is seeking treatment. Care access is strongly influenced by two factors, ability to pay - which, for many people, is impacted by insurance coverage - and the availability of appropriate services.

Study focus. The Legislative Program Review and Investigations Committee (PRI) sought to examine access to substance use care, focusing on accessibility for youth with either private (i.e., commercial) or public insurance, through a study authorized in April 2012. The public insurance component of the study is limited to the state's Behavioral Health Partnership (BHP), its Medicaid program for mental health and substance use services, while the commercial insurance aspect is restricted to fully-insured plans.³ (Self-insured health plans are not governed by state law.)⁴

This report examines Connecticut's agencies and laws involved in health insurance plan offerings and decisions regarding substance use care. A second report, examining the state's treatment services capacity for insured youth, will be issued in early 2013.

Key findings. Fully-insured private health plans cover behavioral health treatment, but not some types of in-home care that is offered to a few groups of BHP participants. The terms of coverage may be influenced by the state and federal parity laws, but the federal law is not fully enforced by the Connecticut Insurance Department (CID).

¹ National Survey on Drug Use and Health (NSDUH) 2008-09 State Estimates.

² "Access to Treatment for Adolescents with Substance Use and Co-Occurring Disorders: Challenges and Opportunities," Stacy Sterling, Constance Weisner, Agatha Hinman, and Sujaya Parthasarathy, *Journal of the American Academy of Child & Adolescent Psychiatry* 49(7): 637-646, July 2010. And: "Type of Health Insurance and the Substance Abuse Treatment Gap," Ellen Englert Bouchery, Henrick J. Harwood, Joan Dilonardo, and Rita Vandivort-Warren, *Journal of Substance Abuse Treatment* 42: 289-300, 2012.

³ A fully-insured plan is one whose financial risk is borne by a health insurer (instead of by the employer).

⁴ The U.S. Department of Labor, the U.S. Department of Health and Human Services (HHS), and the Internal Revenue Service have oversight of self-insured and governmental plans. The labor department receives complaints and inquiries, conducts investigations when necessary, and has enforcement authority for self-insured plans. The Centers for Medicare and Medicaid Services (CMS), which is part of HHS, has the same role for government plans.

The extent of substance use treatment coverage effectively accessible to an individual enrolled in a plan is decided by the insurance carrier's determination of medical necessity through a process called utilization review. Under state law, there is no requirement that a decision to deny coverage be made by the most appropriate practitioner (e.g., an addiction board certified psychiatrist) or rely on the criteria that is widely agreed to represent consensus regarding the appropriate level of care and duration of treatment.

There is widespread belief among families, providers, and staff in several state agencies that needed substance use treatment is easily available only to people who can either access state-provided services or afford to pay independently for care. Contrary to these perceptions, Connecticut's commercial fully-insured plans do authorize substance use treatment coverage - even at high levels of treatment (above regular outpatient counseling). Although the data are imperfect, they indicate 88 percent of all these treatment requests are approved. The authorization rates vary among plans and levels of care. Overall, the BHP has higher rates.

Residential treatment coverage is an area in which parents, providers, and advocates cited particular difficulty accessing coverage. For these requests to fully-insured plans, there are lower approval rates (73 percent overall, but 46 percent among only pre-admission requests), but not significantly higher overturn rates for the denials that are appealed all the way to the insurance department's external review process.

There are appeals processes available to enrollees or providers whose requests are denied, and generally there is agreement that appeals success - in cases where the request is appropriate - hinges on seeking assistance with the appeal and submitting as much supporting documentation as possible. Utilization review and the appeals process require substantial un-reimbursed time from providers, to the point that it could be negatively influencing appeals volume. There are, however, ways in which the appeals process could become more user-friendly for enrollees.

Recommendations: Rationale and goals. This report makes many recommendations with the overall goal of improving insured youth's access to appropriate substance use treatment care.

This is a critical goal from a fiscal policy perspective because substance use has tremendous costs to society, families, and individuals. About eleven percent of all government spending is dedicated to decreasing and addressing substance use. People who abuse or are dependent on substances account directly for a large portion of hospital inpatient (32.3 percent) and judicial system costs, and indirectly for many other costs.⁵ The vast majority (90 percent) of people who are or will become dependent on substances began using as adolescents, so it is important to address problem use early, in the optimal way.⁶ Furthermore, the program review committee heard during this study about a few incidents of direct cost-shifting to the public sector: To get better coverage of behavioral health care, parents have sought out the Department

⁵ "Addiction Medicine: Closing the Gap Between Science and Practice," The National Center on Addiction and Substance Abuse at Columbia University, June 2012. Accessed June 29, 2012 at: <http://www.casacolumbia.org/upload/2012/20120626addictionmed.pdf>.

⁶ "Adolescent Substance Use: America's #1 Public Health Problem," The National Center on Addiction and Substance Abuse at Columbia University, June 2011. Accessed May 23, 2012 at: <http://www.casacolumbia.org/upload/2011/20110629adolescentsubstanceuse.pdf>.

of Children and Families' Voluntary Services⁷ or enrolled their young adult offspring in HUSKY D (one group included in the BHP).

The report's recommendations, taken together, aim to accomplish three objectives:

1. improve the insurance department's behavioral health-related oversight of the commercial plans within its jurisdiction (fully-insured);
2. require fully-insured plans' substance use treatment coverage decisions be made in a timely manner, using appropriate practitioners and methods; and
3. make the appeals process more user-friendly for enrollees of both fully-insured plans and the BHP.

In addition, the program review committee recommends:

1. The information from this report should be incorporated into the Select Committee on Children's report card, with the assistance of staff from the Program Review and Investigations Committee.

Report structure. Substance use treatment coverage in insurance policies - including what is required by mental health parity laws - is explained in Section I. The process insurance carriers use to determine whether requested treatment is covered in an individual situation, utilization review, and recourse for the denied enrollee are described in Section II for commercial insurance and Section III for the BHP. State agency oversight of health plans and assistance to enrollees are explored in Sections I and IV. Appendix A contains an overview of the study's methods, and further detail applicable to each of the sections is found in other appendices.

⁷ About three-quarters of children accepted into Voluntary Services in 2011 had some form of insurance, according to data provided by the Department of Children and Families.

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Insurance Coverage

Insurance coverage of substance use treatment is influenced by many factors; one is federal and state mental health parity laws. This section briefly explains the parity laws, describes how they are enforced in Connecticut, and makes recommendations to strengthen enforcement. In addition, the extent of substance use treatment coverage by this state's fully-insured and Medicaid plans is noted.

MENTAL HEALTH PARITY LAWS

Mental health parity laws generally are intended to put a plan's coverage for mental health conditions equal to its coverage for physical health (i.e., medical) conditions. Some parity laws specifically exclude certain types of behavioral health problems, such as substance use disorders.

Parity laws vary among states, and state laws differ from the federal laws, which were recently revised. The Connecticut and federal parity laws are compared in the table and text below. Additional details on both are provided in Appendix B. Neither the Connecticut nor federal parity laws apply to this state's entire Medicaid program.

Table I-1. Comparison of the Connecticut and Federal Mental Health Parity Laws		
	<i>Connecticut</i>	<i>Federal</i>
<i>Included</i>		
Mandate for coverage	✓	ACA*
Substance use disorders	✓	✓
Focuses on parity regarding:	Financial burden for enrollee	Quantitative (e.g., co-pays, visit limits) and non-quantitative (e.g., utilization review) treatment limitations
<i>Applicable Plans</i>		
Fully insured	✓	✓
Self-insured		✓
Group	✓	Large group only (>50 employees); also ACA*
Individual	✓	ACA*
Non-federal government employee		✓
Public health insurance	CHIP	Medicaid managed care, CHIP; also ACA*
<p>*The federal Patient Protection and Affordable Care Act of 2010 (ACA) contains some provisions regarding mental health parity that will become effective by January 1, 2014. Specifically, the ACA: 1) mandates coverage for and extends the parity law protections to the types of plans that will be required to provide an essential health benefits package (described in Appendix B), including new individual plans and certain other Medicaid plans; 2) extends federal parity protections to all individual plans; and 3) mandates coverage for benefits for new small group plans, except those that are self-insured. Source: PRI staff analysis of state and federal laws and rules; and "Mental Health Parity and the Patient Protection and Affordable Care Act of 2010," Amanda K. Sarata, Congressional Research Service, 2011.</p>		

Connecticut's Laws

Connecticut's parity laws (one each for group and individual policies) require a fully-insured policy to cover treatment for a wide range of behavioral health conditions, including substance use disorders.⁸ The laws also prohibit a policy from including any provisions that place a greater financial burden on a plan enrollee for the diagnosis or treatment of behavioral health disorders, compared to physical health conditions.⁹

Fully-insured plans issued in Connecticut covered 1,094,789 people in 2010.¹⁰ The state parity law also extended to the children enrolled in HUSKY B (the Children's Health Insurance Program), who numbered 15,270 in State Fiscal Year 2011.¹¹

Federal Laws

The 2008 federal parity law (P.L. 110-343) does not mandate behavioral health benefits, but it forbids large group health policies that offer them from imposing greater financial requirements or treatment limitations than exist for medical benefits.¹² The requirements or restrictions placed on mental health or substance use care cannot be greater quantitatively or qualitatively. In addition, the 1996 federal parity law's spending limit was extended to substance use disorders. Further parity protections were given by the Patient Protection and Affordable Care Act (ACA) of 2010, which expands the groups to whom the federal laws apply, removes spending limits, and mandates behavioral health coverage for certain plans.

The 2008 law's interim final rule (i.e., regulation), issued on February 2, 2010, established criteria (described in Table I-2 below) for judging whether any behavioral health restrictions were greater than those for medical benefits.¹³ Despite the detail provided by the interim final rule, there is some debate among federal agencies, advocates, and health plans over what should be acceptable or expected under the 2008 federal mental health parity law. A final rule will eventually provide additional clarification.

⁸ The laws state that plans are required to reimburse a variety of licensed and certified health care providers for covered conditions, which are those included in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, commonly referred to as the DSM. Substance use disorder is listed in the DSM at the stages of abuse and dependence. The DSM is currently under revision, with a new, fifth edition expected in 2013. The most recent draft version (as of November 2012) would expand the definition of a substance use problem, with the aim of making earlier intervention covered by insurance plans.

⁹ C.G.S. Secs. 38a-488a and 38a-514

¹⁰ PRI staff calculations using the "Consumer Report Card on Health Insurance Carriers on Connecticut," Connecticut Insurance Department, October 2011. Enrollees likely include some residents of other states.

¹¹ "Annual Report, State Fiscal Year 2011," Connecticut Department of Social Services. Accessed June 4, 2012 at: <http://www.ct.gov/dss/lib/dss/pdfs/reports/annualreportsfy2011.pdf>.

¹² The law is widely known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

¹³ IRS: 26 CFR Part 54; DOL: 29 CFR Part 2590; HHS: 45 CFR Part 146. Federal Register, Vol. 75., No. 21, Tuesday, February 2, 2010. Effective for plan years beginning July 1, 2010.

Table I-2. Criteria for Assessing Compliance with the 2008 Federal Parity Law			
<i>Requirement / Limitation Type</i>	<i>Examples</i>	<i>Parity Principle</i>	<i>Criteria to Use</i>
Quantitative	<ul style="list-style-type: none"> • Co-pay • Visit limit 	No more restrictive or burdensome	Favorably compare to at least half of requirements / limitations for medical benefits, in at least four out of six benefit classifications*
Qualitative	<ul style="list-style-type: none"> • Protocol used to make utilization review decisions (including step-care)** • Provider network admission standards 	Comparable and not more stringent, except to "the extent that recognized, clinically appropriate standards of care may permit a difference"	Evaluate equally factors that could result in limitations for medical and behavioral health care; the assessments might not reach comparable results
<p>*The benefit classifications are: inpatient in (1) and out (2) of network; outpatient in (3) and out (4) of network; emergency care; and prescription drugs. **Step-care or fail-first policies require a patient to first engage in and not respond to a covered lower level of care or take less expensive covered medication before coverage will be given for a higher level of care or more costly prescription drugs. Source: PRI staff review of the MHPAEA federal regulations issued on February 2, 2010; and "Mental Health Parity and the Patient Protection and Affordable Care Act of 2010," Amanda K. Sarata, Congressional Research Service, 2011.</p>			

Plans had to comply with the 2008 law starting in October 2009. The law applies to policies for private and public sector employers with over 50 employees, regardless of whether the policies are fully- or self-insured.¹⁴ An estimated 59 percent of Connecticut’s non-Medicare-eligible population is covered by an employer-based health plan; it is unclear what portion is served by small employer plans and therefore lacks federal parity protections.¹⁵

Connecticut's Oversight of Fully-Insured Policies' Compliance with the State & Federal Parity Laws

The Connecticut Insurance Department's (CID's) Life and Health Division is charged with reviewing health policies' compliance with all applicable state and federal laws, including mental health parity.¹⁶ Four staff (who also have other tasks) review all documents a potential enrollee receives, checking to ensure that each mandated benefit is included and that all other laws are followed. If one or multiple violations are found, a letter is sent to the policy's health plan, explaining what needs to be corrected before CID approval will be given. These letters and any other relevant correspondence are kept by the department.

¹⁴ Self-funded non-federal government plans with over 100 employees may elect to opt out. It also applies to Medicaid managed care plans; Connecticut's Medicaid programs are not managed care.

¹⁵ "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>. The state figure presented is a multi-year average.

¹⁶ The Life and Health Division also reviews life, disability, and other policies for compliance with all relevant laws.

Monitoring. The insurance department reported to program review committee staff that documentation aggregating the results of health insurance policy reviews for compliance with state and federal laws is not kept. Therefore, the *program review committee could not determine the number of times violations of mental health parity laws were discovered*; insurance department staff stated they do not believe any had been detected within the last five years. Violations of other aspects of state or federal law, however, may be somewhat common. Insurance department staff said that usually there is a list of items requiring correction by the carrier.

Review focus. *CID review of policy compliance with the state and federal mental health parity laws focuses mainly on quantitative limitations, and on whether the policy includes behavioral health care as required by the Connecticut law.* The insurance department stated it does not view the state's mental health parity law as including non-quantitative treatment limitations. The Office of the Healthcare Advocate disagrees with that interpretation.

The state law appears vague.¹⁷ Clarification through a statutory change could be helpful, particularly since the 2008 federal mental health parity law, which provides clearer tests for compliance, does not currently apply to individual policies, which are covered by the Connecticut parity law. Given the uncertainty surrounding details of the most recent federal parity law, however, the program review committee concludes it would be prudent to wait for that law's details to be finalized, before adjusting Connecticut's parity law.

Quantitative limitations. CID has long checked that policy financial coverage limitations (e.g., annual or lifetime amounts) for behavioral health coverage are not greater than for medical care, as required by the state parity law. The department adjusted this review in one respect when the federal parity law was passed, and then again when subsequent, requested clarification from the federal government was received.

CID does not review, however, whether the point at which different behavioral health treatments (e.g., number of psychotherapy visits or days in inpatient care) or levels of care are subject to review for re-authorization for additional treatment, is similar to medical services. There is ongoing debate among federal agencies, advocates, and health plans about to what type of medical care outpatient psychotherapy – and intensive non-inpatient care – should be compared, for this purpose.

Non-quantitative treatment limitations. Federal law forbids greater non-quantitative treatment limitations, unless appropriate guidelines require differently or the limiting standards were applied equally to behavioral health and medical care. Yet, *the insurance department does not check for plan compliance with this aspect of the federal mental health parity law.*

For example, CID staff do not check to see that the utilization review timing for levels of care (e.g., whether preauthorization is required) is the same for medical and behavioral health care.¹⁸ Neither is there review of whether step-care or fail-first requirements are included, and if

¹⁷ The law could be interpreted expansively as forbidding any limitation that ultimately results in a greater financial burden, or narrowly as prohibiting only limitations that expressly and clearly impact the financial burden.

¹⁸ CID staff stated they review the plans overall to see whether utilization review timing for various levels of care are included and noted this timing tends to be the same for a given level of care, across types of care.

so, whether these restrictions are clinically appropriate or based on reasonable, federally-allowed processes. The insurance department stated that it does not receive the documents – the protocols and supporting materials – necessary to review this aspect and lacks the authority necessary to request them for the pre-issuance review.¹⁹

CID further notes that it does not have the health care expertise necessary to make the appropriateness determination. The department has contracted with the University of Connecticut's medical school faculty for evaluation of particular protocols when it detects potential problems in medical necessity determinations. Until this year, there had not been any assessments of behavioral health protocols.

The program review committee concludes that although the protocols could easily be acquired for review, state resources could be better used in ways other than pre-emptive review of behavioral health protocols for compliance with the qualitative aspect of the federal parity law. CID has promptly addressed one such provision, regarding step-care, brought to its attention.

Overall. Although this study is focused on behavioral health insurance coverage, shortcomings identified in the context of mental health parity may be affecting CID's enforcement of health policy compliance with other laws. Consequently, the program review committee determines that a broader recommendation is warranted.

The Connecticut Insurance Department's review of fully-insured plans for compliance with state and federal laws should be tracked and more thorough. The results of reviews are not tallied and compiled, making it difficult for the department to identify and address (through bulletins or directives to individual carriers) any deficiencies that repeatedly emerge. Tracking the policy deficiencies would take minimal additional staff resources in the short term, potentially lead to fewer deficiencies and therefore less staff time in the long term, and yield more complete oversight of compliance with the insurance laws. The program review committee recommends:

2. The Connecticut Insurance Department should track, monitor, and address deficiencies repeatedly detected through pre-issuance health insurance policy review.

The deficiencies should be tracked by type, policy, and health carrier. The data should be compiled and analyzed at least annually to determine whether there are deficiencies that repeatedly arise across carriers or within a particular carrier's plans. If any such patterns are found, the department should take appropriate action to address the issue.

Specific to behavioral health coverage, *the department has in some ways seemed reluctant to enforce the full potential extent of mental health parity laws.* For example, the department has never requested an advisory opinion from the Office of the Attorney General to receive guidance on how to interpret the state's parity laws alone or in conjunction with the federal laws. In addition, when the most recent federal parity law and, later, its interim final rule

¹⁹ C.G.S. Secs. 38a-481 and 38a-513 give the insurance department the authority to review and approve individual and group fully-insured policies, respectively.

was released, the insurance department did not issue a bulletin explaining the law and notifying carriers they were expected to comply, a step CID regularly takes when major changes have been adopted. Furthermore, for a few years, the Office of the Healthcare Advocate has requested CID examine a certain carrier for parity violations, and only recently have those requests produced a limited review effort by the insurance department.

The insurance department needs to explore ways in which it can fully enforce the parity laws. The program review committee's staff research found two possible documents that could help health insurance carriers demonstrate policy compliance as part of the fully-insured health policy approval process, which would therefore involve minimal or no additional CID resources. One is the U.S. Department of Labor's "self-compliance tool" posted on the Employee Benefits Security Administration's website.²⁰ Another is URAC's²¹ health plan accreditation standards, with the provisions relevant to compliance with the parity laws available on the Parity Implementation Coalition's website.²² The program review committee recommends:

3. The insurance department shall, by September 1, 2013, report to the legislature's Public Health Committee and Insurance and Real Estate Committee on the precise method it will use, starting one month after said date, to check for compliance with the state and federal mental health parity laws, for carriers or plans under its jurisdiction.

In making this selection, the insurance department shall examine and assess for fitness the methods set out by the U.S. Department of Labor and URAC, as well as any other detailed methods discovered by the department or brought to its attention. As part of its evaluation process, the department shall hold at least one public meeting at which stakeholders - including relevant state agency personnel, health insurance carriers, and the general public - are invited to share their input and propose other thorough methods.

The report to the legislature shall:

- **describe and address the comments shared at the public meetings;**
- **include an assessment of each potential method; and**
- **append the written comments and suggestions of the Healthcare Advocate.**

The method selected and the results of its implementation shall be included in the report on the regulation of managed care (required by C.G.S. 38a-478a) annually submitted to the governor and legislature.

The reporting to the committees of cognizance is meant to give legislators with subject matter jurisdiction the opportunity for informed review of the insurance department's decision and keep them abreast of efforts to fully implement the parity laws.

²⁰ <http://www.dol.gov/ebsa/pdf/cagappa.pdf>. Pages 22 through 29 address parity.

²¹ URAC is formerly known as the Utilization Review Accreditation Commission. It accredits a variety of health care coverage arrangements, including utilization review companies, health plans, and preferred provider organizations.

²² <http://parityispersonal.org/node/242>

SUBSTANCE USE TREATMENT COVERAGE IN CONNECTICUT FULLY-INSURED & MEDICAID PLANS

Levels of Care

Traditionally there are six major settings or levels of care for substance use disorders (listed by decreasing intensity):

1. Inpatient, involving medically managed or monitored care
2. Residential rehabilitation, which can have stays that are short (under 30 days), intermediate, or long-term (90 days and over)
3. Supervised community living arrangement with clinically managed services, such as a halfway house
4. Partial hospitalization or day or evening treatment, usually for someone who is transitioning out of residential care
5. Intensive outpatient, with nine hours or more weekly of clinical (e.g., individual and group counseling) services
6. Outpatient

All the fully-insured policies offered by Connecticut health maintenance organizations (called, simply, health plans or carriers throughout this report) and the state's Medicaid Behavioral Health Partnership (BHP) include substance use treatment coverage for each of these levels of care, except for supervised community living arrangements.²³ (None covers rehabilitative wilderness programs.) BHP additionally covers:

- congregate settings, for youth in DCF care (e.g., therapeutic group homes);
- a greater variety of residential settings, for HUSKY D enrollees; and
- in-home outpatient treatment models, such as Multi-Dimensional Family Therapy.

Some BHP levels of care are limited to particular programs; Appendix C details these and the enrollment groups included in the BHP.

Utilization Review

Although a policy may generally cover a variety of substance use treatment levels, the utilization review process determines if the level and length of treatment requested are medically necessary based upon the medical (or behavioral health) protocols and therefore covered in a particular case.²⁴ Since the rise of managed care in the 1980s, utilization review practices have been widely used by plans in an effort to contain costs and ensure enrollees receive appropriate care.

²³ One health plan has some options that include mental health residential treatment (not substance use residential treatment) as an add-on option, with a correspondingly higher cost to enrollees.

²⁴ Connecticut's statutory definition of utilization review, in C.G.S. Sec. 38a-591a, broadly encompasses a range of health care management techniques, but the most commonly used is this one.

The process and components of utilization review are described in Sections II and III. The timing of the review and typical length of treatment initially authorized are explained below.

Timing. Utilization review may be done at three different times:

- prospectively, when preauthorization or precertification is required;
- concurrently, when treatment is underway, usually for additional care beyond what has already been authorized (but also when preauthorization was not obtained); or
- retrospectively, after treatment has been given.

Generally, Connecticut fully-insured health plans and BHP require prospective review (i.e., preauthorization) for inpatient and residential treatment. Nearly all require preauthorization for partial hospitalization, but there is substantial variation in whether it is mandatory for intensive and regular outpatient treatment. Appendix C includes a table detailing the precise preauthorization requirements of each health plan and BHP.

Initial authorized length of treatment. Usually prospective or concurrent authorization is given for a specific length of treatment (e.g., days in a facility, number of outpatient visits). Program review committee staff requested and received information on these initial authorization periods from BHP and three of Connecticut's health plans offering fully-insured policies. The individual health plans were not identified by name, however; instead, each was signified by a letter.

Table I-3 shows the number of days typically first authorized at a given level of treatment varies a small amount among the Connecticut health plans, with one plan (C) reporting slightly longer lengths of treatment.²⁵ BHP's initially authorized timeframes are consistently at or above the level of the commercial fully-insured plans, particularly for residential rehabilitation. It is important to note, however, that for all plans, the length of covered treatment depends on the utilization reviewer's assessment of an individual's specific circumstances.

²⁵ This plan, however, also generally had lower coverage approval rates in 2011 for enrollees seeking substance use treatment at intensive outpatient and higher levels of care.

Table I-3. Typical Initial Authorized Timeframes for Various Levels of Substance Use Treatment for Youth Covered by Certain Major Connecticut Health Plans, 2012

	<i>Commercial Fully-Insured</i>			<i>Medicaid (BHP)</i>
	A & D	B & E	C	
Inpatient (generally detoxification)	1-3 days	Did not respond	2-5 days	3-4* days
Residential rehabilitation	3-6 days		3-7 days	14-28 days
Community living arrangement (e.g., halfway house)	---		---	---
Partial hospitalization	4-6 days		7-10 days	Child: 10 units/ 14 days Adult: 3-5 units/ 7 days
Intensive outpatient	3-12 days		12-15 days	15 units in 42 days
Outpatient (in-office, non-detox)	---		---	90 visits/ 12 months
Outpatient detox.	---		---	21 units/days; or 7 for alcohol
In-home treatment models	---		---	630 units/ 6 mos.
<p>*Inpatient detoxification includes hospital-based and free-standing programs. (Inpatient psychiatric treatment initial authorization is for one to three days, unless the hospital is part of the Bypass program and therefore receives initial authorization for five days.)</p> <p>Source: PRI staff analysis of information provided by the CT Association of Health Plans and DSS.</p>				

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Commercial Insurance Utilization Review and Appeals

Utilization review and any resulting appeals are governed by federal and state laws.²⁶ At the federal level, major changes were made to both fully-insured and self-insured plans' processes because of the Patient Protection and Affordable Care Act (ACA) of 2010, as described in Appendix D. Connecticut adjusted its laws to match the strictest ACA requirements, adding internal appeals timeframes, extending the external appeals filing period, and adopting new denial and appeals rights notification requirements. Consequently, in this state, utilization review and appeals steps newly look somewhat similar for all types of plans.²⁷ The resulting process is shown in a flowchart on the following page and explained further in Appendix E.

This section features areas where the program review committee believes the state's utilization review laws (which apply only to fully-insured plans) could be improved to ensure timely and appropriate decisions, particularly for behavioral health treatment requests. It also highlights analysis of the state insurance department and major carriers' data on utilization review initial decisions, internal appeals, and external reviews (i.e., external appeals), with additional data given in Appendix F.

Initial Determinations

The utilization review process begins when the health carrier (or its designated utilization review company) receives a request for coverage from an enrollee or the person's provider. The reviewer determines whether the person was enrolled in the plan at the time of the request, if the benefit is included in the policy, and if the treatment is medically necessary or appropriate. The vast majority of coverage denials are due to lack of medical necessity as determined by the utilization reviewer.²⁸ The health carrier is forbidden from making personnel hiring or compensation decisions based on the likelihood that an individual reviewer will deny benefits.²⁹

Once coverage approval is given, it cannot be rescinded.

Decision timeframes. The timeframe within which a utilization review decision must be made varies based on the type of utilization review (e.g., prospective) and situation urgency. Prospective or concurrent review must result in a decision within 72 hours if the situation is

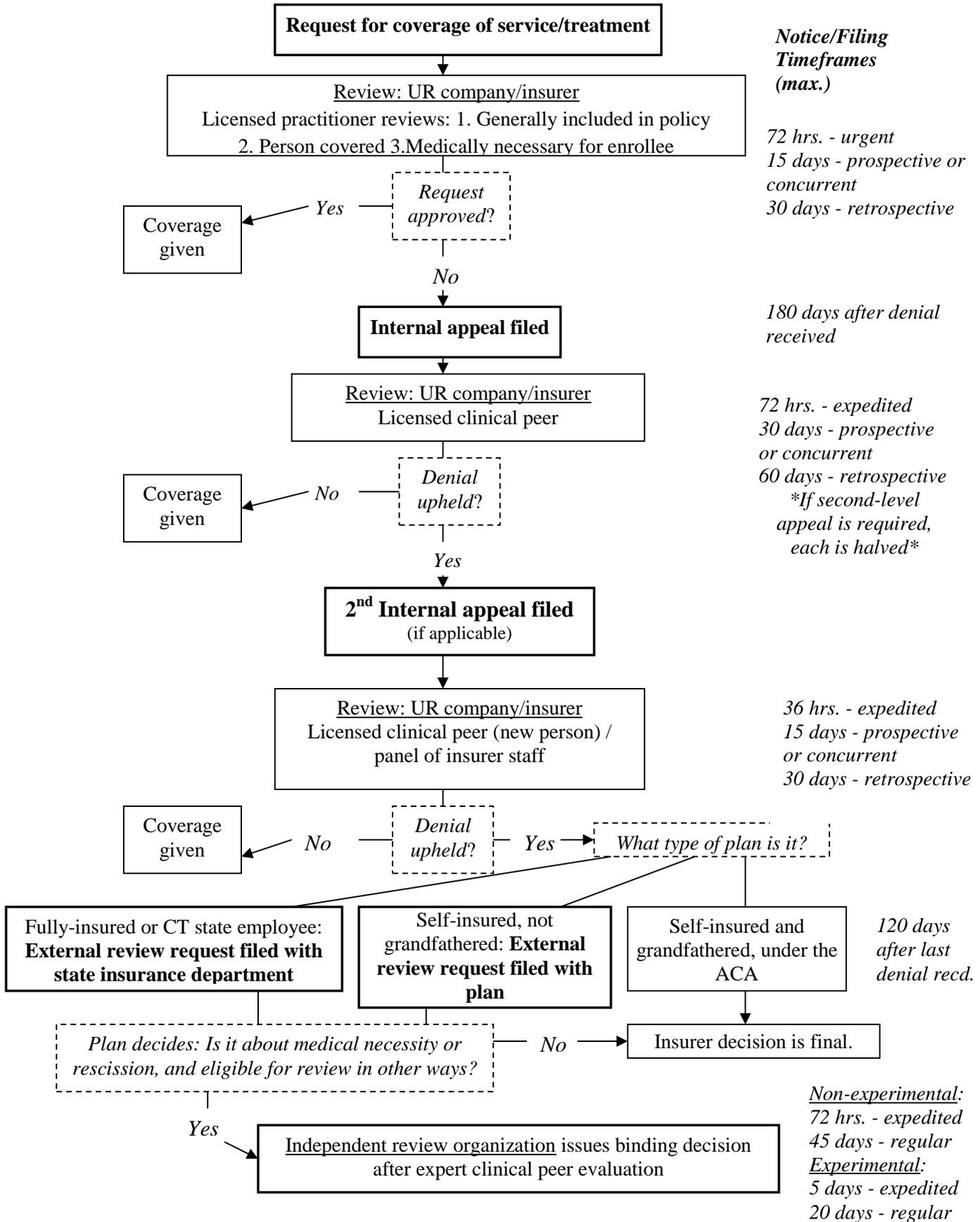
²⁶ Utilization review is not required to be conducted; the utilization review laws only apply when a plan chooses to engage in utilization review, as most do.

²⁷ A company usually purchases a policy in the state of its corporate headquarters, according to the Connecticut Insurance Department. For example, a Massachusetts-based company likely would buy a Massachusetts policy for its employees. That policy – if fully-insured – would have to follow Massachusetts insurance laws that would apply even to the company's employees in other states. A company may, however, purchase a policy specific to its employees who work in a different state (e.g., Connecticut). In that situation, the insurance laws and processes of the different state would apply.

²⁸ Other reasons for denial are that the treatment is considered experimental and investigational, or coverage spending limits have been reached.

²⁹ C.G.S. Sec. 38a-591c(d)

Fig. II-1. Commercial Insurance Utilization Review (UR) and Appeals Process



urgent, or 15 calendar days if it is not.³⁰

Research, providers, and advocates agree that when a person with a substance use or co-occurring disorder is ready to engage in treatment, care must be immediately available. If treatment is not easily reachable, the person may not be ready to surmount the necessary psychological or other (e.g., insurance) barriers – either for a while, or ever again. Recognizing this reality, the President’s Commission on Model State Drug Laws in 1993 called for substance use treatment to be immediately available (i.e., no preauthorization) to those under the influence of a substance or in need of detoxification. The Commission additionally recommended that all other substance use treatment utilization review decisions be made within 48 hours of a request.³¹

Connecticut’s utilization review law falls short of these goals. The existence of a preauthorization requirement – which is widely accepted – effectively prevents treatment from being immediately accessible. Public hearing testimony and program review committee staff research indicated that preauthorization coverage decisions for higher-level substance use treatment (i.e., above intensive outpatient) often take only a few hours, but it is unclear whether decisions regarding lower levels of this care are equally speedy. There is precedent for mandating quicker prospective review decisions in non-urgent situations: Massachusetts and New York require these decisions (for any type of health care) within three business days.

The program review committee concludes based on its research that all requests for substance use treatment are urgent, given the high potential for harm to self and others. Substance use requests therefore need especially prompt decisions. The program review committee recommends:

4. C.G.S. Sec. 38a-591a(38) shall be amended to include in the definition of "urgent care request" any prospective or concurrent utilization review request involving treatment for a substance use or co-occurring disorder.

Specific to Connecticut fully-insured plans. Certain requirements - about who makes medical necessity decisions and the protocols used - apply only to Connecticut fully-insured plans (but not self-insured plans in the state).

Reviewer qualifications. *The initial review can be conducted by any licensed or certified health care practitioner; no familiarity with the condition for which treatment has been requested - or with the treatment itself - is required.³² According to staff of the Connecticut*

³⁰ Under C.G.S. Sec. 38a-591d and the ACA, a situation may be deemed “urgent” by either the enrollee’s provider or the insurer, when the standard timeframe could harm the person’s life, health, or ability to regain maximum function. If the urgent care request involves concurrent review, the 72-hour timeframe only applies if the request was made at least 24 hours before the already-authorized treatment ends. If additional information is necessary to evaluate the request, the insurer must inform the enrollee or the enrollee's representative (e.g., provider) within 24 hours of the request, and give them at least 48 hours to respond.

³¹ "Model Laws - Volume 4: Treatment," National Alliance for Model State Drug Laws. Accessed October 11, 2012 at: <http://www.namsdl.org/mlV4.htm>.

³² C.G.S. Sec. 38a-591c(a)(1) states that a health carrier must contract with healthcare professionals (defined by C.G.S. Sec. 381-591a(23) as licensed practitioners) to administer utilization review and clinical peers (defined in

health plans offering fully-insured policies, a behavioral health request reviewer is generally either a master's level clinician (e.g., licensed clinical social worker), or a nurse. That person lacks the authority to deny a request under the plans' policies - but not under state law.

If the initial reviewer feels a denial may be appropriate, the request and related materials are given to a different licensed practitioner, who the health plans report is a board-certified psychiatrist for behavioral health-related requests. This psychiatrist usually is board-certified in the subspecialty of child and adolescent psychiatry, if the request involves behavioral health care for an adolescent. A request for substance use treatment for an adult might not be handled by a psychiatrist or physician with addiction board certification.³³ The plan personnel said the psychiatrist attempts to have a "doc-to-doc" conversation with the requesting practitioner, before determining whether to make an adverse determination.

There are three compelling reasons why the program review committee concludes that the person who makes the initial coverage denial decision should be required to have expertise in the condition or treatment at issue:

- *Most denials stand through lack of appeal, and generally health plans have a strong short-term financial interest in denying coverage;*
- *There is no meaningful legal remedy for enrollees who have been wrongly denied and suffered damage; and*
- *A higher level of expertise is required by Connecticut's utilization review laws on internal appeals and external review decisions, Connecticut's medical malpractice law as it applies to expert witnesses, and four nearby states' laws for utilization review initial denials.*³⁴

Although the first reason is grounded in results from the committee's review of insurer data on appeal requests, which was limited to behavioral health treatment, the other two reasons apply to all types of health care. Therefore, the program review committee recommends:

5. C.G.S. Secs. 38a-591a through 38a-591e shall be amended to require, beginning January 1, 2015, an adverse determination (initial or otherwise) based on medical necessity or experimental or investigational treatment be rendered only by a licensed practitioner who has: a) a doctoral or medical degree; and b) either: i) appropriate national board certification, including at the subspecialty level where available; or ii) actively practices and typically manages the condition of the patient or provides the service requested.

C.G.S. Sec. 38a-591a(7)). C.G.S. Sec. 38a-591d, which describes utilization review procedures, does not indicate that a clinical peer is required to be decision-maker for an initial adverse determination, but such a person is required (by C.G.S. Sec. 38a-591e(c)(B)) to be involved in the internal appeal decision.

³³ The carriers stated that the addiction board is not widely recognized, and therefore substance use requests generally are not matched to a practitioner with that board certification. Subsequent program review committee research revealed that the psychiatry addiction board is recognized, while the physician addiction board open to other types of physician is not yet.

³⁴ See Appendix E for details.

Appropriate national board certification for adult substance use treatment is considered to be an addiction board for psychiatrists and other physicians. Denials involving substance use treatment for children may be issued only by a licensed practitioner who has: 1) a doctoral or medical degree; 2) board certification in child and adolescent psychiatry or psychology; and 3) prior training or clinical experience in adolescent substance use treatment.

Beginning September 1, 2013, these requirements apply to internal appeals decisions.

Delaying the implementation of these requirements for initial denials will give carriers time to adjust their workforces if necessary.

Basis of the medical necessity determination. The utilization reviewer(s) is required by state law to use the carrier's documented clinical review criteria, collectively referred to as a "protocol," which are to be based on sound clinical evidence. Consistent application of the criteria is to be actively overseen by the carrier.³⁵

Another factor in the decision is the state's definition of "medical necessity." This is defined by Connecticut statute as treatment that is clinically appropriate, follows accepted standards of practice, and is the most efficient of the likely effective options; see Appendix E (page E-4) for the actual language.³⁶ There is disagreement among CID, advocates, and health plans about how, for any given determination, the carrier's protocol intersects with the state's medical necessity definition. Some believe that the state's definition takes precedence, while others place the two on equal footing.

There is widespread agreement among practitioners, health plans, and researchers that the American Society for Addiction Medicine's Patient Placement Criteria-2nd Revision (ASAM PPC-2R, called the "ASAM manual") is the best method to use for determining what level and duration of substance use treatment is necessary. This manual is used as a substance use treatment protocol by at least one plan and the BHP's administrative services organization (except for its BHP business, which uses a protocol based on the ASAM manual). The American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry also, and more recently, have issued guidelines, but those are not as comprehensive.

Among parents, providers, and advocates, there is particular concern about residential treatment coverage decisions.³⁷ Two protocols (applying to three health plans) for this level of care were reviewed by program review committee staff.³⁸ The committee staff found the protocols did not match up well to the ASAM-PPC 2R, or include references to peer-reviewed

³⁵ C.G.S. Sec. 38a-591c

³⁶ Self-insured plans' medical necessity definition is not set by state or federal law. These plans in any state may use their own definitions of medical necessity or the third-party administrator's.

³⁷ Interestingly, placement into inpatient substance use care - not residential treatment - was the level of care respondents to the committee's practitioner survey indicated there is most often disagreement among practitioners (53 percent of respondents to the question). Residential treatment initiation was roughly tied for second with intensive outpatient care initiation (39 and 40 percent of respondents to the question).

³⁸ The remaining carrier's protocol was requested but not received in time for committee staff analysis.

literature or professional association guidelines that would justify the deviations. One plan's residential criteria seemed especially at odds with the ASAM manual, as described further in Appendix G. Its complete behavioral health protocols currently are being reviewed by the University of Connecticut medical school's psychiatry department for compliance with the state protocol laws and mental health parity laws, at the behest of the Connecticut Insurance Department.³⁹ A discussion of the resources used by health care practitioners and plans to make (respectively) substance use treatment and coverage decisions - with a focus on residential treatment - is found in Appendix G.

Because the protocols play a key role in determining whether requested treatment is covered by insurance, it is important they are medically sound. Therefore, the program review committee staff recommends:

6. C.G.S. Sec. 38a-591c(a)(2) shall be amended to require the substance use and co-occurring disorder treatment criteria to be either:

- 1) the most recent version of the American Society for Addiction Medicine's Patient Placement Criteria (ASAM PPC), by reference; or**
- 2) a protocol that is**
 - a) developed as required under state law;**
 - b) accompanied by a document that both compares every aspect of the protocol with the ASAM PPC and gives citations to peer-reviewed literature or professional society guidelines that justify each deviation from the ASAM PPC; and**
 - c) reviewed and accepted by the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF) for adherence to the prevailing standard of care for adults and adolescents, respectively.**

Alternative considered. The program review committee considered but decided against recommending amending state statutes to prohibit utilization review for substance use treatment while instituting minimum coverage requirements (as done by Pennsylvania). The committee determined that the health plan data (limited though they are), described later in this section, and consistency of practitioner placement recommendations do not, at this time, call for such a drastic step.

Coverage Denials & Internal Appeals

Data received from Connecticut health plans indicates that less than half of denied requests for youth substance use treatment are appealed. The committee staff research discovered there are many reasons why a coverage denial might not be appealed, including:

³⁹ The protocol was given 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. The Office of the Healthcare Advocate has been complaining to the insurance department for a few years that this carrier has been violating the mental health parity laws in multiple aspects of its utilization review practices.

- The enrollees (or parents) may feel discouraged, unsure of the ability to challenge a large company, reluctant to request from providers the supporting documentation that often is the key to reversing the denial, and not even know exactly what types of documents would be helpful;
- The provider may not have the time or the financial ability to take the unreimbursed time required to pursue and support an appeal; or
- The carrier may be able to convey to the prescribing practitioner what treatment would be considered medically necessary, and the practitioner and/or the enrollee accepts and is reasonably satisfied with that alternative course of action.

The program review committee staff concludes that the statutory denial notice language could be adjusted to better inform enrollees about how to pursue and support an appeal. Therefore, the program review committee staff recommends:

7. C.G.S. Sec. 38a-591d(e) shall be amended to include the following language in the denial notice:

1) A statement that if the covered person or the authorized representative chooses to appeal this adverse determination:

a) the person may benefit from free assistance from the Office of the Healthcare Advocate.

b) the person is entitled and encouraged to submit supporting documentation for consideration during the appeal, including letters from all treating providers, provider treatment notes, and enrollee/parent narrative(s) describing the problem(s), when each arose, and symptoms. The covered person or their representative has the right to ask providers for these documents.

2) A statement that appeals are sometimes successful.

Connecticut state law distinguishes between internal appeals (handled by the utilization review company or health insurance carrier) of coverage denials based on medical necessity and internal appeals for other reasons, for timeframe and denial notification requirements.⁴⁰ The notice of a medical necessity coverage denial upheld on appeal that is sent to the enrollee must include information on remaining internal and external appeals processes, as well as notice that assistance is available from CID and the Office of the Healthcare Advocate (OHA). *A notice that a denial for reasons other than medical necessity has been upheld is not required to have the latter component, although that assistance is available.*⁴¹

⁴⁰ When the appeal is regarding a denial for other reasons, the carrier must decide the appeal within 20 business days, although an extension is allowed in certain circumstances.

⁴¹ C.G.S. Sec. 38a-591f

To make the statutes consistent and clarify for consumers that CID and OHA services are available for non-medical necessity denials upheld on internal appeal, the program review committee staff recommends:

8. C.G.S. Sec. 38a-591f(d) shall be amended to require that a notice of an upheld denial for a determination not based on medical necessity include a statement disclosing the covered person's right to contact at any time the insurance commissioner's office, and that the person may benefit from free assistance from the Office of the Healthcare Advocate at any time, with contact information for both offices listed.

Recent Utilization Review & Internal Appeals Results

The CID collects some behavioral health utilization review data but there are limitations. Consequently, youth 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 health maintenance organizations (referred to as "health plans" in this report) by PRI staff. All five carriers provided fully-insured plan data for 2011 only, according to primary diagnosis.

It is important to note that the "approval" data include all approvals (full and partial), as the plans responded that not all track partial approvals. Consequently program review committee staff could not determine to what extent coverage was granted for the entire duration originally requested by the provider.

Appendix F contains tables and accompanying descriptions of the program review committee staff analysis of the plan data, practitioner survey data (with survey methods explained in Appendix H), and CID external review data. The analysis was limited to inpatient, residential, partial hospitalization, and intensive outpatient treatments, because the utilization review policies for regular outpatient treatment varied among the plans.

The main observations from the health plan data were:

- Each of the four traditional behavioral health treatment settings above the regular outpatient level was sought by and covered for only a very small portion of youth enrollees (less than 0.3 percent).⁴²
- When prospective, concurrent, and retrospective requests for substance use treatment were combined, a strong majority - 88 percent across levels of care - was approved (before any appeal was filed).

⁴² 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 above the level of outpatient.

- For inpatient care, about nine of every ten requests were approved, while for partial hospitalization, about 12 of every 13 were approved. For intensive outpatient, nearly all requests were approved.
- Residential rehabilitation was the most difficult level of care for which to obtain substance use coverage, with about a 46 percent pre-admission approval rate⁴³ and a 73 percent approval rate across request timings. This is consistent with the anecdotal information gathered from the study's June public hearing and committee staff's interviews.
- Plans' coverage approval rates within each level of substance use care varied. For example, within inpatient care, the approval rates ranged from 67 to 97 percent.
- Less than half of denied requests involving residential care or partial hospitalization for substance use were appealed internally, and a very small portion progressed through both the internal and external appeal processes.
- About nine in every ten requests to extend substance use treatment at the three high levels (inpatient, residential rehabilitation, and partial hospitalization) were approved, although there was some variation among plans and levels of care.
- Substance use treatment requests had lower approval rates and internal appeal rates than mental health treatment requests, for inpatient, residential, and partial hospitalization care.

External Appeals

The ACA mandates that all commercial insurance enrollees in non-grandfathered plans have access to an external appeal process that complies with the National Association of Insurance Commissioners' (NAIC) Model Act. Fully-insured plan participants⁴⁴ can access Connecticut's external review process because the state changed its law to fully comply with the Model Act. The state process is administered by the insurance department.⁴⁵ The external review processes for Connecticut fully-insured and non-grandfathered self-insured plans are detailed in Appendix E (beginning on page E-8).

⁴³ The rate at which the first requests involving residential treatment were approved may in fact be higher. There is indication from the plan data that at least a portion of one plan's concurrent review requests for this level of care were in fact the first requests.

⁴⁴ The sole exception is that enrollees of the self-insured State Employee Health Plan may also use CID's external review process because the Office of the State Comptroller agreed the plan would follow the state's insurance laws.

⁴⁵ The CID was allowed by the federal government to keep its external review process (as revised by P.A. 11-58) because it met the "strict" definition of the ACA's external review aspect. Under the ACA, states were categorized by the Department of Health and Human Services based on whether they met: the "strict" definition of the law (all 16 standards enumerated in the July 2010 rules - 28 states as of January 1, 2013); a "similar" definition (13 standards given in the June 2011 Technical Release No. 2011-02 from the U.S. Department of Labor) adequate for the transition period until full standards become effective in January 1, 2015 (12 states plus D.C.); or neither (10 states). Fully-insured plans in a state whose process is inadequate must use a federal process administered by the U.S. Department of Health and Human Services. (Source: The Center for Consumer Information and Insurance Oversight, CMS. Accessed December 12, 2012 at: http://cciio.cms.gov/resources/files/external_appeals.html.)

Self-insured plans are allowed by the ACA to choose between a federally administered external review process or a process similar to that in the Model Act. The insurance department noted that these plans frequently rely on the process developed by their third party administrators.⁴⁶

External appeals involve a binding decision from an independent review organization's expert reviewer(s).⁴⁷ The Connecticut Insurance Department provided data on external appeal applications and decisions, for 2009 through 2011; analysis is presented below and in Appendix F (starting on page F-17).

Applications. Very few coverage requests that are denied result in external review applications, according to the health plans' data. A large portion (58 percent) is not appealed internally - which is the first step toward external review eligibility - and just 11.5 percent of internal appeals that are unsuccessful are pursued to external review.

The program review committee staff concludes that the insurance department's external review guide for consumers - which accompanies every final coverage denial letter - could be revised to make an enrollee better informed about how to navigate the process. Therefore, program review committee staff recommends:

9. CID should revise the CID consumer external review guide to include:

a. the availability of free assistance at any step of the process, from the Office of the Healthcare Advocate, with contact information listed;

b. emphasis on the importance of submitting complete documentation if a person decides to appeal, including: letters from all treating providers, provider treatment notes, enrollee/parent narrative(s) describing the health problem(s), when each arose, and symptoms; and notice that the enrollee has the right to ask his/her providers for these documents; and

c. the consumer-overturn rate (including both full and partial overturns) for external reviews, as a three-year average.

Rejected applications: Overall. In recent years, between 30 and 42 percent of all external review applications (which have totaled 270 to 302 annually) have been rejected based on a preliminary review. This assessment determines only whether the application is complete (after follow-up with the applicant as described above, if needed), as well as if plan type and nature of the denial are eligible to be reviewed under state law.

Rejected applications: Incomplete. A number of applications each year have been rejected due to incomplete documentation - 18, in 2011. The insurance department's data showed

⁴⁶ A self-insured employer plan may choose a health insurance carrier as its third-party administrator. When this happens, the carrier may handle all or some aspects of the plan's claims administration, including conducting utilization review.

⁴⁷ The decision is binding on both the plan and the enrollee, although there may be limited judicial recourse available to the latter; see Appendix E, page E-13 for more information.

that, annually, between 50 and 59 percent of incomplete applications are missing only one component – and in these cases, it is always either the carrier’s final denial letter (80 percent or more of the time) or the insurance card (the remainder).

The insurance department staff believes that few submitted applications are missing a final denial letter but are procedurally eligible. In other words, they suspect that if the data system allowed for multiple rejection reasons to be recorded, most applications that show rejection based on incompleteness would have also had procedural ineligibility indicated. The department also asserted that enrollees generally are well-informed about the process for requesting a new insurance identification card, given that the card is required to receive coverage for health services. The insurance department is reluctant to deviate from the current submission requirements because the state's process is based on the NAIC Model Act and therefore approved by the U.S. Department of Health and Human Services.

*The existing data appear to indicate, however, that a portion of otherwise eligible requests are being denied for lack of either a final denial letter or identification card, while a carrier that has one could easily look up the other electronically.*⁴⁸ The program review committee believes that HHS is likely to embrace a change that makes the external review process easier for consumers, but recognizes the importance of retaining federal approval. Therefore, the program review committee recommends:

10. The Connecticut Insurance Department should ask HHS by January 31, 2013 if it would approve of requiring an applicant for external review to submit either (instead of both) the final denial letter or the enrollee identification card. If HHS responds affirmatively, then the CID should promptly change its application requirements accordingly. If HHS responds negatively, then CID should add to the external review consumer guide that the enrollee may contact the carrier for a free copy of the letter and/or the identification card, if necessary.

Rejected Applications: Plan ineligible. The CID letter an applicant receives if the application is not accepted due to plan ineligibility (e.g., self-insured plan) does not contain information to help the applicant learn whether there is a different appeal process available. CID states that such information cannot be provided because the department does not know what might be available.

The program review committee believes that a small amount of added language could assist enrollees in further pursuit of reconsideration with little effort from the insurance department. Generally the next steps are clear by plan type.⁴⁹ The program review committee recommends:

⁴⁸ The requirement to submit both these documents makes sense to the program review committee if the insurance department were conducting the review for external appeal eligibility, as it did before the 2011 changes made to comply with the ACA (except for applications involving denials based on contract terms), but not in the current context of the carriers completing that review.

⁴⁹ The steps should be: Medicaid – Contact the Department of Social Services to request a Fair Hearing, if not already done. Out-of-state plan – Contact the relevant state’s insurance department. Self-insured plans – Contact the plan to learn if is ACA-grandfathered; if not, request an external review, directly to the plan. Non-federal

11. CID should add to the external review application rejection letter information on the potential next step for the enrollee, for applications rejected due to plan ineligibility. When the enrollee's plan type is known, the next step specific to the enrollee's plan type should be included; when not, the range of plan types and corresponding next steps should be listed.

Accepted applications. Just over one-third of accepted external review applications involved behavioral health (mental health, substance use, or a co-occurring diagnosis of both disorders), for 2009 and 2011, with a somewhat higher percentage in 2010. Treatment requests for substance use disorders, alone, were a very small portion of external review cases accepted – with none at all, in 2010. When co-occurring disorders were added, between 14 and 17 percent of annual cases involved a substance use diagnosis.

Decisions. External review decisions (for all types of care) were in favor of the enrollee (either full or partial overturns of the carrier's decision) between 31 and 40 percent of the time, annually, between 2009 and 2011. There were some differences in the decision overturn rates - by enrollee age, type of diagnosis (substance use, mental health, co-occurring, or physical health), and level of care for those with a diagnosis involving substance use - but none was statistically significant.

governmental plans – Contact the plan. Massachusetts and New York executive branch agencies that oversee external reviews go one step further and provide telephone numbers for each.

Medicaid Behavioral Health Utilization Review and Appeals

Connecticut's Medicaid mental health and substance use services are carved out to the Behavioral Health Partnership (BHP). The Partnership is jointly administered by the Departments of Social Services (DSS), Children and Families (DCF), and Mental Health and Addiction Services (DMHAS), along with an oversight council that includes providers.⁵⁰ Enrollees are those in HUSKY A through D, as well as Charter Oak Health Plan and DCF Limited Benefit members.

The BHP's program's administrative services organization (ASO), ValueOptions, conducts utilization review (as described below) and other tasks. However, utilization review for HUSKY D enrollees seeking residential treatment is handled by DMHAS and its administrative services organization, Advanced Behavioral Health.⁵¹

This section focuses on providing BHP utilization review information similar to that given for commercial insurance in Section II. A couple of recommendations are made that aim to benefit BHP enrollees. Appendix I contains details on the BHP utilization review and appeals processes, and Appendix J gives data beyond what is presented below.

Initial Determinations

The administrative services organizations are forbidden by contract from making personnel hiring or compensation decisions based on the likelihood that an individual reviewer will deny benefits.

Decision timeframes: BHP. These vary somewhat based on the type of utilization review (e.g., prospective) and situation's urgency. The preauthorization timeframes for inpatient and detoxification treatment are a few hours, while the requirement for other levels of care is one business day. Generally, these are shorter than the timeframes in statute for commercial insurance, and within the program review committee's recommendation for commercial insurance's review of substance use treatment requests.

Decision timeframe: HUSKY D residential treatment. The decision must be made within three hours of the receipt of all necessary information.

Reviewer qualifications: BHP. A licensed behavioral health clinician who holds at least a master's degree reviews the request and may approve it. If the reviewer believes the request does not meet the level of care guidelines in the protocol, there is consultation with a psychiatrist, psychologist, or addiction specialty society-certified physician to help clarify the

⁵⁰ The oversight council is required by C.G.S. Sec. 17a-22j. The group meets monthly.

⁵¹ HUSKY D is Medicaid for Low-Income Adults, which used to be the medical assistance portion of State-Administered General Assistance (SAGA). Connecticut is awaiting a federal decision on its proposal to revise HUSKY D eligibility requirements. For the first time, parental income would be considered for young adults 19 through 26 living with a parent.

situation.⁵² If the doctoral-level practitioner confirms that the request appears to not meet the guidelines, then a "doc-to-doc" conversation is held with the requesting provider.

ValueOptions attempts to match psychiatrists and physicians with utilization requests in an appropriate way, although there is no contractual requirement to do so. If the request is for the care of a child or adolescent, generally the decision will be made by a psychiatrist who is board-certified in child and adolescent psychiatry, or at least by one who has substantial experience working with that population. If the request is for substance use treatment, the reviewer (if not a physician) might not be board-certified in addiction (though it has some psychiatrists who are) because ValueOptions believes doctoral-level practitioners generally are knowledgeable about and have experience giving substance use treatment. Effectively, then, the credentials of the utilization reviewers for substance use related treatment are about the same for Connecticut fully-insured plans and the BHP, according to information shared by the plans and BHP.

It would be more consistent with the proposed recommendation for commercial fully-insured plans if a proposed recommendation were made to allow BHP coverage denials to be issued only by doctoral-level practitioners with appropriate board certification and training or clinical experience. However, given the BHP's higher request approval rates and the greater provider satisfaction with BHP coverage decisions indicated by the program review committee's research, the program review committee recommends:

12. When the BHP administrative services organization contract is re-bid, the BHP should consider what steps and terms would be necessary to ensure that denials are issued only by practitioners with appropriate board subspecialty certification and appropriate prior clinical experience or training.

Reviewer qualifications: HUSKY D residential treatment. The initial reviewer must be licensed and have had at least five years' experience 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.)

Basis of the medical necessity determination. The definition of medical necessity for those receiving state services is in statute; it is somewhat more expansive than the definition that applies to commercial fully-insured plans.⁵³ In conjunction with the definition, ValueOptions follows BHP-specific guidelines for adults and children. The guidelines are based on the American Society of Addiction Medicine's Patient Placement Criteria – 2nd Revision (ASAM PPC-2R), and reviewed annually by ValueOptions for possible changes. Proposed revisions have multiple layers of review within ValueOptions and the BHP Oversight Council, which ultimately must vote whether to approve any alterations to the criteria, for them to become effective. HUSKY D residential treatment uses the Connecticut Client Placement Criteria and the ASAM manual, as well as the statutory medical necessity definition.

⁵² The company currently does not have any psychologists but they are allowable, under the contract terms.

⁵³ See Appendix I, page I-2 for detail.

Coverage Denial Notices & Appeals

Notices. 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. *Although the notices contain contact information for the legal assistance hotline, they do not include it for the Office of the Healthcare Advocate, which - like some legal aid staff - is experienced in appealing utilization review denials.* The program review committee recommends:

13. BHP coverage denial notices should state that enrollees can seek free assistance from the Office of the Healthcare Advocate and list the office's contact information.

Appeals. Unlike commercial insurance enrollees when they sign a provider's waiver stating they will be held liable for costs not covered by insurance, Medicaid enrollees cannot be charged for care given in the absence of authorization. Most BHP enrollee appeals are withdrawn when the enrollee learns that fact, according to DSS.

The BHP appeals processes are different for providers and enrollees. The provider process is exclusively an internal one, with two levels, while the enrollee process incorporates internal and, through the state fair hearing process, external venues.⁵⁴ The provider and enrollee may both request an appeal; each would be handled separately.

For HUSKY D residential treatment, the second-level internal appeal is decided by a DMHAS staff person who is a licensed practitioner. The external appeal is a DMHAS fair hearing.

Recent Utilization Review & Appeals Results

The BHP provided utilization review and appeals results for youth (ages 12 through 25) for 2009 through 2011. The program review committee's full analysis is in Appendix J.

Approximately 12 percent of BHP youth enrollees received covered behavioral health care per year.⁵⁵ Overall, coverage for substance use and co-occurring services appears easier to access for BHP youth enrollees compared to youth in fully-insured commercial plans. Using three-year averages except where noted, the highlights (specific to substance use and co-occurring disorder treatment unless otherwise indicated) are:

- The initial overall approval rate when examining treatment requests for intensive outpatient and higher levels was 96 percent, exceeding the commercial rate of 88 percent.

⁵⁴ It is a DSS fair hearing - with a DCF representative present if the request is for a child, or a DMHAS representative for an adult - in most cases. DCF handles the process entirely for children receiving its Limited Benefit. HUSKY B and Charter Oak Health Plan enrollees' external review process is a desk review done by DSS healthcare practitioner staff.

⁵⁵ The actual percent of BHP youth enrollees receiving behavioral health care may be higher: HUSKY D enrollees are included in the number of youth covered but those (if any) who received only residential treatment would not have been included in the number who received covered care.

- Each level of care examined had an initial full approval rate of 94 percent or more, with residential treatment at 96 percent (and 100 percent for HUSKY D enrollees) - substantially higher than the commercial rates (which ranged, by level, from 73 percent for residential treatment to 98 percent for intensive outpatient).
- Across levels of care, when denials for all reasons are considered, no more than 15 percent of denials are appealed, but there is variation among the levels of care; residential treatment had the highest maximum appeal rate at 54 percent (though the numbers are very small). The overall appeals rate is lower for treatment of these disorders, compared to mental health, but the numbers are small.
- When all levels of care and denial reasons are included, about one-third (34 percent) of appeals for substance use and co-occurring treatment are overturned, a rate comparable to mental health appeals results (29 percent overturned).
- According to the BHP's analysis, when only denials based on medical necessity are examined, about one-quarter (24 percent) of substance-use and co-occurring treatment denials are appealed, with an overturn rate of 15 percent.
- Very few enrollees - only nine - applied for a fair hearing for any type of behavioral health care treatment; of the three that reached the fair hearing stage, one found for the enrollee.

Utilization Review Consumer Assistance and Oversight

In Connecticut, three state entities are involved in helping enrollees with the utilization review process: the Connecticut Insurance Department (CID), the Office of the Healthcare Advocate (OHA), and the Office of the Attorney General (AG). Enrollees may:

- register complaints with any of the three;
- receive assistance in resolving complaints from CID or in attempts to gain coverage for requested health care treatment from the other two state offices; and
- seek out online resources at the CID and OHA websites.

Additional consumer protections are provided through CID's regulation of utilization review companies and health insurance carriers offering fully-insured policies.

While giving a brief overview of these functions, this section focuses on areas where the program review committee believes state consumer assistance and oversight functions could be strengthened: through improved web information and more proactive use of information already received by CID. Full descriptions of state consumer assistance and oversight activities are contained in Appendices K and L, respectively.

Complaints & Casework

All three state entities receive health insurance complaints in a variety of ways. There is no simple way to learn the volume of unique complaints; reportedly many people contact the three simultaneously, and CID refers utilization review-related complaints to OHA. Behavioral health complaints make up a very small share of CID and AG complaints, but a larger portion (up to 25 percent) of OHA complaints. Utilization review, specifically, is the subject of a much larger share of CID's behavioral health complaints than its medical complaints.⁵⁶

CID's complaint resolution process focuses on informing consumers of their rights and appropriate next steps, while being watchful for law violations by insurers. In contrast, complaints received by OHA and the AG often become advocacy casework, where staff assist individual enrollees (or parents) and providers with navigating the utilization review request or appeals processes. CID forwards utilization review denial complaints to OHA so even those complaints may end up receiving advocacy help.

Websites

The Office of the Healthcare Advocate's website provides the public with some information about utilization review and how to appeal a coverage denial, but it is out-of-date and not comprehensive. Providing a greater amount and higher quality of assistance online

⁵⁶ From 2009 through 2011, 36 percent of the 130 behavioral health complaints were about utilization review - which was the subject of just six percent of the 5,657 medical/surgical complaints.

could lead to greater success for enrollees seeking coverage approval and lighten OHA staff's growing workloads. The Advocate reported that an overhaul will be imminently unveiled. *The program review committee expects the revamped website will remedy the current shortcomings.*

There is limited information for enrollees available on the insurance department's website. *Someone relying solely on the CID website, however, would not know that the healthcare advocate's office can provide external review and internal appeal assistance or anything about the internal appeal process (e.g., timeframe requirements or steps in the process).* The program review committee believes it would make sense to ensure those who visit the CID website have easy access to the full extent of the state's online consumer assistance. Therefore, the program review committee recommends:

14. The Connecticut Insurance Department should provide on its relevant web pages a prominent link to the Office of the Healthcare Advocate's website with an accompanying statement that the office can provide the public and providers with free assistance throughout the coverage decision (i.e., utilization review) process.

Utilization Review Oversight

The state insurance department monitors and enforces fully-insured plans' compliance with utilization review laws in a variety of ways:

- tracking consumer complaint trends;
- licensing utilization review companies (including the health plans offering fully-insured plans, which often do the reviews in-house);
- annually surveying the licensed companies, investigating possible problems shown by the survey, and fining companies for law violations;
- thoroughly reviewing each insurer every five years;
- accepting, evaluating, and potentially acting on complaints from other state entities; and
- compiling utilization review-related and other data for the Consumer Report Card and another, complaint-focused publication.

The program review committee finds greater attention needs to be given to the last method listed above. This task should have two functions: making utilization review information available to consumers to aid them in selecting a plan, and allowing CID to monitor utilization review results. Reviewing these results specific to behavioral health care should be a focus for CID, given the Healthcare Advocate and AG's frustrations with this area and the historically unequal coverage for it. In both function areas, however, the insurance department's performance is falling short.

The CID report card lacks the approval and appeals rates that are needed to make the Consumer Report Card data meaningful to consumers and to aid the department in identifying potential problems. Committee staff did these calculations for the behavioral health utilization review process information in the 2011 report card and discovered outlier carriers with substantial differences in denial rates for various types of requests. The insurance department was unclear regarding whether its staff had previously performed the calculations but indicated it

had not followed up with the outlier carriers to learn why their fully-insured plan denial rates were so high. The reasons for the high denial rates could be one or some of several - for example, violations of utilization review or mental health parity laws, a particular enrollee situation, differing interpretations of the language used in the data request (e.g., whether "inpatient" is inclusive of residential treatment), or tremendously varying practices.

The program review committee concludes the insurance department should determine and then address the reasons as necessary to ensure carriers are complying with the utilization review and parity laws. The committee further finds that CID currently has this authority broadly under current statute, but does not exercise it. Therefore, language is needed to specifically authorize and require these actions. The program review committee recommends:

15. C.G.S. Sec. 38a-478l shall be amended to require the insurance commissioner to analyze the Consumer Report Card utilization review data and investigate the reasons for all statistically significant differences among carriers. Where necessary, the commissioner shall take reasonable action to address the reasons for any such differences.

Furthermore, neither the report card nor the complaint report is easily accessible to the public - the intended consumers - on the department's website. To improve the accessibility and usefulness of information collected to consumers, the program review committee recommends:

16. CID should: a) include both raw numbers and rates (e.g., percent of each type of requests denied) for all utilization review data presented in the Consumer Report Card; and b) make available the Consumer Report Card and insurer complaint rankings through its main web page, specifically at: Consumer Services – Health Insurance; and Consumer FAQs.