PRI Study: Update Highlights

June 2012

Access to Substance Use Treatment for Privately Insured Youth

Background

In late April 2012, the program review committee authorized a study to assess insurer coverage and enrollee use of substance use treatment. In addition, the project aims to examine supply and demand for those treatment services. The study is limited to youth aged 12 to 25 who have private health insurance, focusing on adolescents under 18.

In Connecticut, about 8% of youth ages 12 through 17 and 24% of those 18 through 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.

Private health plans that are fully insured generally are regulated at the state level, while self-insured private plans (in which the employer assumes the financial risk of coverage) are subject to federal oversight. Plan coverage of substance use treatment is affected by mental health parity laws at both government levels – as well as by the psychiatry profession's diagnosis manual, which is under revision.

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.

To complete this update, PRI staff reviewed state and federal laws, as well as related analyses. Staff also examined the literature on substance use treatment, particularly related to youth. Finally, staff conducted preliminary interviews with: staff from multiple state agencies and offices; advocates; treatment providers; and a researcher.

Main Points

Many youth have a substance use disorder, which in the severest form is a chronic, treatable brain disease. Although data on prevalence have limitations, diagnosable substance abuse and dependency among youth clearly exists. Substance use disorders can be treated in a range of settings, with a variety of intensity levels. Treatment for youth can and should take into account several unique characteristics of the age group; family involvement is critical.

The state mental health parity law mandates fully insured private health plans cover substance use disorder diagnosis and treatment. It also requires that the coverage not be more financially burdensome for plan enrollees than that for comparable medical care. Federal parity laws that extend to both fully and self-insured plans are meant to ensure treatment is offered on an equal basis to other medical care. The Patient Protection and Affordable Care Act of 2010 will extend federal parity laws in certain ways, and, for particular plans, establish a mandate for substance use coverage.

Many, if not all, health plans review requested or received medical and behavioral treatment, to determine coverage. This process, utilization review, is regulated by law. If an enrollee is denied coverage, there are internal and external appeals processes available. Disagreement with a utilization review determination often is about whether a treatment is "medically necessary."

Next Steps

PRI staff are in the process of conducting research.

Staff aim to obtain insurer and insurance department data on youth substance use treatment coverage, use, utilization review denials, and appeals. Staff also anticipate surveying treatment providers to collect information on capacity and demand for the various levels of services in Connecticut, as well as on provider experiences regarding insurer coverage. In addition, further stakeholder interviews and other research activities will be conducted.

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Section I: Overview of Youth Substance Use and Treatment

In Connecticut, approximately eight percent of adolescents (12 through 17) and 24 percent of young adults (18 through 25) recently met the clinical criteria for "abuse" or "dependence" on alcohol or illicit drugs. The data on the extent of use are imperfect but clearly indicate problematic youth drug use is present. A person whose use reaches the abuse or dependence stage is said to have a substance use disorder, based on the psychiatric profession's manual, which is currently under revision. Youth with a substance use disorder can enter into a range of treatments and settings. Various models of behavioral therapy that engage a young person's family have been proven effective for this population. Just over two-thirds of Connecticut adolescents in treatment in March 2010 were being served by facilities that offered specific treatment for that population.

What is Substance Abuse, and Substance Use Disorder?

Substance abuse, in the common vernacular, is the misuse of alcohol, tobacco, or any other drug, including otherwise legal medications. A drug is any chemical taken that affects the body. Substance abuse, as an umbrella term, appears to be in the process of being replaced by "substance use disorder."

Stages of use. In clinical terms, substance abuse is a distinctive stage of use, and different from dependence. Stages of use, before abuse, varied among sources consulted, but the American Academy of Pediatrics' clinician handbook for detecting and treating adolescent substance use gives five stages:

1. Experimentation: first use
2. Non-problematic use: sporadic, usually without negative consequences
3. Problem use: adverse social consequences first appear
4. Abuse
5. Dependence[1]

Most clinicians, and those who have abused or become dependent on a substance, would add a sixth stage: recovery. Those in recovery have used substances in the past with negative consequences and currently do not use substances. Someone in recovery can begin to again use substances, returning to a different stage of use.

Not every person will experience all these stages of use. Substance use does not become clinical abuse or dependence, for all people (either adolescents or adults) who take an illicit drug.

[1] John Knight, Timothy Roberts, Joy Gabrielli, and Shari Van Hook, "Adolescent Alcohol and Substance Use and Abuse," in *Performing Preventive Services: A Bright Futures Handbook*, American Academy of Pediatrics, 2010. Accessed June 5, 2012 at: http://brightfutures.aap.org/pdfs/Preventive%20Services%20PDFs/Screening.PDF

Addiction. The stage of dependence is commonly called addiction. Recent research shows that addiction is a chronic brain disease, because repeated drug use leads to changes in the brain's structure and function long after use has stopped. Although addiction is a chronic disease, it is treatable, with various interventions able to decrease or stop use and improve social functioning. A person who is abstinent, in recovery, may have a relapse, as with other chronic illnesses. The relapse rate for addiction is similar to that of hypertension, asthma, and Type I diabetes, estimated at between 45 and 70 percent.[2]

Definitions. Abuse and dependence are defined among health care professionals and by Connecticut law (C.G.S. Sec. 17a-680) according to the most recent version of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, called the DSM. In the current manual, which is under revision, abuse and dependence are separate disorders collectively referred to as "substance use disorders" for drugs other than alcohol.[3] The term also has become preferred among advocates (rather than "substance abuse"), and this study is extending it to include alcohol. The abuse and dependence criteria are described in the table below.[4]

Table I-1. Substance Use Disorders Criteria

Substance abuse is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one or more of the following, occurring at any time in the same 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household).
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).
3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

[2] "State Substance Abuse Treatment for Adults," Connecticut General Assembly, Legislative Program Review and Investigations Committee, 2008.

[3] The DSM also includes "substance-induced disorders": intoxication, withdrawal, and mental states brought on by a substance (e.g., psychosis, anxiety).

[4] Although alcohol abuse and alcohol dependence are considered separate disorders from substance abuse or dependence, the criteria are the same.

Table I-1. Substance Use Disorders Criteria

Substance dependence is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:

   a. a need for markedly increased amounts of the substance to achieve intoxication or desired effect.

   b. markedly diminished effect with continued use of the same amount of the substance.

2. Withdrawal, as manifested by either of the following:

   a. the characteristic withdrawal syndrome for the substance.

   b. the same (or a closely related) substance is taken to relieve or avoid symptoms.

3. The substance is often taken in larger amounts or over a longer period than was intended.
4. The person experiences a persistent desire (or unsuccessful efforts) to reduce or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chainsmoking), or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

Source: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., Text Revision.

Definition revision. As mentioned above, the DSM is under revision. The most recent public draft of the proposal would combine substance "abuse" and substance "dependence" into a single "substance use disorder," while carving out a separate but similar "alcohol use disorder."[5]

[5]The precise "substance use disorder" would be specific to the exact substance (e.g., cocaine), similarly to now. (Source: "DSM-5 Development," American Psychiatric Association. Accessed June 7, 2012 at: http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=431# and

Committee staff review indicates that while the criteria for the disorder would largely remain the same as what are now the separate abuse and dependence criteria,[6] these important changes would be made:

- "craving or a strong desire or urge to use a specific substance" is an additional criterion;
- two or more of the criteria within a 12-month period would need to be met, for diagnosis, except for those who are in recovery (instead of a single one for abuse, or three for dependence);
- those in recovery would be considered to still have the disorder for as long as craving is experienced;[7] and
- the clinician would need to indicate severity based on the number of criteria met.[8]

Media coverage has indicated that the new language would make substance use diagnosable when it is not currently. The shift would allow for earlier, insurance-reimbursable treatment under those health plans that continued to rely on DSM use criteria. In addition, recovery care would newly be included. The proposal, overall, has generated controversy, according to media reports.

Co-occurring disorders. A substantial portion of adolescents and adults with substance use disorders have other mental illnesses. The co-occurring mental illnesses drug-using adolescents specifically might have include attention deficit hyperactivity disorder, oppositional defiant disorder, and conduct problems, as well as depressive or anxiety disorders.[9]

The presence of a co-occurring disorder has implications for treatment. As noted in the program review committee's 2008 report *State Substance Abuse Treatment for Adults*:

> Concerns are raised when health care practitioners treat one disorder without treating or being aware of the other. The best chance at success and recovery requires that both disorders be treated at the same time. If not, both disorders often get worse.

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http://www.dsm5.org/proposedrevision/pages/proposedrevision.aspx?rid=452#)

[6] The abuse criterion of recurrent substance-related legal problems would be eliminated, and one new criterion would be added: "Craving or a strong desire or urge to use a specific substance."

[7] It appears that those in recovery (i.e., experiencing none of the criteria except for the additional craving-related one) will be diagnosable with the disorder, with a specification that the person's disorder is in early (3 to less than 12 months) or sustained (12 months or longer) remission.

[8] Two or three criteria would be considered moderate severity, while four or more would indicate severe severity.

[9] "What are the unique needs of adolescents with substance use disorders? Principles of Drug Addiction Treatment: A Research-Based Guide (Second Edition)," National Institute on Drug Abuse, NIH. Accessed June 8, 2012 at: http://www.drugabuse.gov/publications/principles-drug-addiction-treatment/frequently-asked-questions/what-are-unique-needs-adolescents-substance-use-d

People who have abused drugs for a period of time may develop ongoing physical problems, as well.

What is the Extent of Youth Substance Use in Connecticut?

The precise extent of youth substance use in Connecticut is unclear, due to multiple shortcomings of the relevant data sources, as detailed described in Appendix A.[10] Despite these limitations, the available data can provide a general sense.[11] Key points for the most recent state-level data are summarized below. When the data indicate Connecticut's use is substantially different from average U.S. use, national-level data are also noted.

Use reaching clinical "abuse" or "dependence" stage. Approximately 7.8 percent of adolescents (12-17) and 23.7 percent of young adults (18-25) abused or were dependent on illicit drugs or alcohol in the past year (for 2008-2009).[12] Youth were over one-fifth of Connecticut treatment admissions recorded by a federal data set, in 2011.[13]

Early use initiation. For a portion of high schoolers, use begins before the teenage years: 15.6 percent had their first alcohol drink other than a few sips and 6.3 percent tried marijuana before age 13.[14] Both figures are lower than the national averages (20.5 and 8.1 percents, respectively). These state 2011 results continue a recent trend of reduced early use. For example, in 2005, Connecticut high schoolers reported early use for alcohol and marijuana at 21.4 and 8.4 percent.[15] There is indication that early use is associated with a higher likelihood of developing a diagnosable substance use disorder.[16]

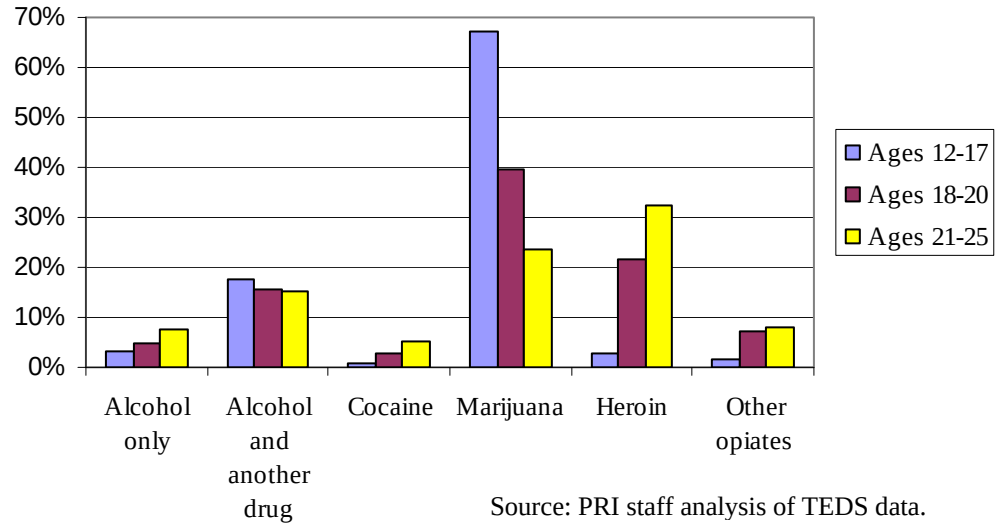
Recent illicit drug use. Approximately 10.3 percent of adolescents and 25.0 percent of young adults used an illicit drug (e.g., marijuana, abuse of prescription drugs) in the past month (for 2008-2009).[17]

Types of illicit drugs. Marijuana is the most popular illicit drug among youth, according to all federal data sources. Among minors' (under 18 years old) 2011 treatment admissions, two-thirds were for marijuana. Heroin and other opiate use accounted for 28 and 41 percent of

[10] Due to the methodological problems, the legislature's Children's Report Card team decided against including any data for its youth substance use indicators.
[11] For the purpose of this study, "substance use" includes alcohol and drugs, but not tobacco products.
[12] National Survey on Drug Use and Health (NSDUH) 2008-09 State Estimates. Because NSDUH gives estimates only for state-level data, the resulting information is not sufficiently sensitive to show statistically meaningful changes over time.
[13] 2011 Treatment Episode Data Set (TEDS): Adolescents were 0.9 percent of admissions, while those 18-20 and 21-25 were 5.8 and 16.1 percents, respectively. TEDS counts admissions across the year, not unique patients/clients, and excludes federal, municipal, and likely unlicensed programs (e.g., private counseling practices).
[14] Youth Risk Behavior Surveillance System (YRBSS) 2011
[15] "2005 CT School Health Survey," Connecticut Department of Public Health. Accessed May 23, 2012 at: http://www.ct.gov/dph/lib/dph/hisr/pdf/yrbs2005ct_codebook.pdf
[16] "Adolescent Substance Use: America's #1 Public Health Problem," The National Center on Addiction and Substance Use at Columbia University. Accessed May 23, 2012 at: http://www.casacolumbia.org/upload/2011/20110629adolescentsubstanceuse.pdf
[17] NSDUH 2008-09 State Estimates

treatment admissions for 18-20 and 21-25 year olds, respectively, in 2009-2011, much higher than for those groups at the national level.[18,19] Anecdotal evidence from practitioners and the media suggests abuse of opiate and stimulant prescription drugs among mainly middle- or upper-class youth may be increasing, both nationally and in Connecticut.[20] The chart below shows the top six primary substances for youth treatment admissions for 2009 through 2011.[21]

Figure I-1. Primary Substance for Connecticut Youth Treatment Admissions, 2009-2011



Source: PRI staff analysis of TEDS data.

Alcohol use. About 24 percent of adolescents have binged on alcohol in the past month, versus 17.7 percent nationally, according to a 2008-09 survey.[22] Data collected by the Connecticut Department of Mental Health and Addiction Services showed that in 2008, 46

[18] PRI staff analysis of TEDS Connecticut data for 2009, 2010, and 2011.

[19] TEDS 2009 national data indicate about 20 percent and 29 percent of 18-20 and 21-25 year old admissions, respectively, were for heroin and opiate use. (2010 and 2011 national data were not available.)

[20] PRI staff interviews conducted in May 2012, and two recent *The New York Times* articles: "Risky Rise of the Good-Grade Pill" (Alan Schwarz, June 9, 2012) and "Prescription Drug Overdoses Plague New Mexico" (Dan Frosch, June 8, 2012). There is substantial evidence and attention to an overall prescription drug abuse epidemic. See, for example, "Prescription Painkiller Overdoses in the U.S.," Centers for Disease Control and Prevention, at: http://www.cdc.gov/vitalsigns/PainkillerOverdoses/index.html.

[21] All data are from TEDS, which counts admissions, not unique individuals. The charts presented combine 2009, 2010, and 2011, for each age group. Substances that did not account for more than six percent of admissions for any youth age group are excluded from the charts (e.g., PCP, cocaine). Consequently, the summed percentages for any age group do not sum to 100.

[22] NSDUH 2008-09 State Estimates

percent of underage college students had been binge drinking in the past two weeks.[23] There is indication that the rates of youth binge drinking, as well as non-binge underage alcohol use, have slightly decreased in the last few years for which data are available.

What is the Treatment for Youth Substance Use Disorders?

Substance use disorder treatment is a broad term that includes a variety of therapies, settings, and intensities. However, there are some aspects of treatment that, according to best practices, should be included when working specifically with adolescents and young adults. No matter the person's age, treatment strategies should be customized to suit the individual's characteristics and needs, as well as the problem severity. The following descriptions draw heavily upon the program review committee's 2008 report cited above, except for the youth-specific information.

Therapies. Behavioral (counseling) therapies may help a person modify behavior and attitudes about substance use. Varieties of these therapies have been proven effective in treatment and supporting recovery. For many, counseling is the major component of treatment. Counseling can be done individually, in groups, and/or with family members.

For a person going through detoxification, medical management may be desired – or, in the case of alcohol, necessary – to ease physical effects.

Pharmacological therapy involves prescription medications to help someone stop abusing drugs and stay in treatment. These medications change the brain activity involved in addiction and can be used to suppress withdrawal symptoms. There are several medications available to assist recovery from alcohol and opiate abuse or dependence. Opiate therapies are methadone, buprenorphine (Suboxone, Subutex), and naltrexone (Vivitrol, ReVia). While research on youth use of these therapies is limited, and could be complicated by parental consent laws, federal government treatment guidelines indicate some or all can be effective.[24]

Self- and peer-help groups such as Alcoholics and Narcotics Anonymous are not generally considered treatment, but are recognized as contributing to or driving a successful recovery for many people.

Settings and intensity of treatment. There is a range of treatment settings available, and within a setting, different intensities are possible. Intensity involves therapy frequency and duration, as well as clinical or other supervision. Generally, the setting and intensity vary according to the stages of treatment, as described below.

[23] CT Department of Mental Health and Addiction Services Substance Use Grant Application to the Substance Abuse and Mental Health Services Administration, Submitted September 2011; data from 2008 CORE survey.

[24] "Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction; A Treatment Improvement Protocol; TIP 40," Center for Substance Abuse Treatment, SAMSHA, HHS. Accessed June 8, 2012 at: http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf

Detoxification and stabilization. Detoxification involves handling the acute physiological effects of stopping use, and possibly also assessment, brief intervention, family involvement, and transfer planning. Depending on the substance and person, it may be done in a hospital or similar setting, with 24-hour medical staff; on an outpatient basis with intensive nurse monitoring; or in a doctor's office. Stabilization is early treatment – assessment and brief intervention – received to alleviate the immediate physical, psychological, or emotional emergencies that the substance use caused. Detoxification and stabilization take three to five days.

Rehabilitation. This stage occurs after the problem has stabilized, and consists of a formal program. It may include medication, behavioral therapies, use disorder education, and other services. Depending on the person's situation, it may be provided in residential settings. Rehabilitation can occur through any of these, listed in decreasing intensity level:

- 24-hour care facility that specializes in substance use treatment;
- Residential facility, offering short-term (under 30 days), intermediate, or long-term (90 days or more) programs;
- Supervised community living arrangements with clinically managed services, such as a halfway house;
- Partial hospitalization or day or evening treatment program, usually for those transitioning out of a residential placement;
- Intensive outpatient services, through a facility or clinic, involving nine hours or more weekly; and/or
- Outpatient.

A patient's treatment might not begin at the most intense level of care, and levels may be skipped, according to what is most appropriate, affordable, and available to the person. The individual's goals at this stage are to remain abstinent and improve functioning. Generally rehabilitation should help a person recognize circumstances that originally triggered use, and help provide the individual with coping strategies to avoid a return to use.

Aftercare/continued care. Upon completion of the primary treatment process, counseling and other therapeutic services may still be received, less frequently than before. Ideally supports are received and in place to maintain recovery. Many people at this stage participate in self- or peer-help groups.

Overall treatment principles. The National Institute on Drug Abuse (NIDA), part of the National Institutes of Health, publishes *Principles of Drug Addiction Treatment: A Research-Based Guide*. The manual establishes and explains several principles, listed in Appendix B, which should underlie and guide substance use treatment. The principles collectively point to the importance of customizing and adjusting treatment based on the individual's characteristics

(e.g., age) and needs, including but expanding beyond the drug problem. One principle also asserts that detoxification alone is insufficient treatment to change long-term drug use.

The NIDA principles also contain some supplementary language that can be illuminating, particularly (paraphrased) that treatment:

- offered early in the disease process is more likely to have a positive impact (i.e., there is no need to hit "rock bottom" before treatment is effective);
- must be available "the moment" people are ready for it, because many are uncertain;
- might need several episodes because addiction is a chronic disease – not because the treatment overall "failed"; and
- duration must be appropriate, of at least three months to reduce or stop use, and better outcomes occurring with longer treatment.

Another document that can guide treatment is the *American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised*. The guide is commonly called either the "ASAM PPC-2R" or "the ASAM manual." The second edition was issued in 2007; the process to produce a third is underway. A 2005 survey of states' substance use directors (i.e., equivalent to Connecticut's Department of Mental Health and Addiction Services commissioner) indicated the ASAM manual was, by far, the treatment planning aid most commonly required of public or publicly contracted providers.[25]

Effective treatment for youth. Adolescents and young adults have certain commonalities that may be taken into consideration, when planning or engaging in substance use treatment.

Still-developing brain. Research indicates that the human brain continues developing from the time a person is born until about the mid-20s. The particular brain area involving behavioral functions – such as judgment, planning, and self-control – develop tremendously during adolescence and young adulthood.[26]

Identity establishment. Peers, families, and other social influences serve as social cues as youth form a sense of who they are. For the same reason, youth may identify strongly with their culture and gender.[27]

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[25] Thirty states required the use of the manual. Gretchen D. Kolsky, "Current State AOD Agency Practices Regarding the Use of the Patient Placement Criteria (PPC) – An Update," The National Association of State Alcohol and Drug Abuse Directors, 2006.

[26] "Young Adult Development Project: Brain Changes," Massachusetts Institute of Technology. Accessed June 11, 2012 at: http://hrweb.mit.edu/worklife/youngadult/brain.html

[27] "ACT for Youth Upstate Center of Excellence; Research Facts and Findings," A Collaboration of Cornell University, University of Rochester, and the New York State Center for School Safety. Accessed May 23, 2012 at: http://www.actforyouth.net/resources/rf/rf_identityformation_1102.pdf

May lack full control over living arrangements/routine. Many adolescents and young adults reside with parents, grandparents, or other guardians. Others may live separately but rely on parental figures for financial and other support. Youth who have received residential treatment may have to return to an unchanged living and social situation that could involve triggers for substance use.

These unique needs and characteristics call for a different treatment approach for youth, compared to that for mature adults. The following counseling treatment models have been proven effective for adolescents, according to the National Center on Addiction and Substance Use at Columbia University. Notably, each involves family participation as a necessary component for treatment effectiveness.

- *Cognitive Behavioral Therapy (CBT) integrating family members*: The aim is to change unhealthy patterns of thinking and beliefs. CBT is an evidence-based treatment for many disorders.

- *Multidimensional Family Therapy (MDFT) for adolescents*: This therapy looks at adolescent use as a network of influences (individual, family, peer, community), and tries to increase positive behavior in multiple settings. The individual and family are counseled both separately and individually.

- *Functional Family Therapy (FFT)*: FFT's premise is that "behaviors influence and are influenced by interactions within the family."[28]

A recent research review shows evidence supporting the addition of Multisystemic Therapy,[29] which NIDA includes as a treatment that has shown efficacy for adolescents. This outpatient model is family-based, involving joint counseling for the individual and family, with the intent of addressing a range of influences on the youth: individual (e.g., attitude toward use), family (e.g., discipline, conflict), peer, and community (e.g., school, neighborhood).[30]

What Substance Use Treatment Services Exist for Connecticut Youth?

A federal agency annually conducts the National Survey of Substance Abuse Treatment Services (N-SSATS), resulting in a point-in-time view of treatment facilities and their clients.[31]

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

[29] Aaron Hogue and Howard A. Liddle, "Family-based treatment for adolescent substance abuse: controlled trials and new horizons in services research," *Journal of Family Therapy* (2009) 31: 126-154.

[30] "Behavioral Treatments for Adolescents," within: National Institute on Drug Abuse, National Institutes of Health Publication No. 09-4180, *Principles of Drug Addiction Treatment: A Research-Based Guide (Second Edition)*, April 2009. Accessed June 11, 2012: http://m.drugabuse.gov/publications/principles-drug-addiction-treatment/evidence-based-approaches-to-drug-addiction-treatment/behavioral-therapies-2

[31] N-SSATS, conducted by SAMHSA, includes all facilities that are either government-operated or state-licensed. Some providers that are neither (e.g., small group counseling practices, hospital-based programs) also participate,

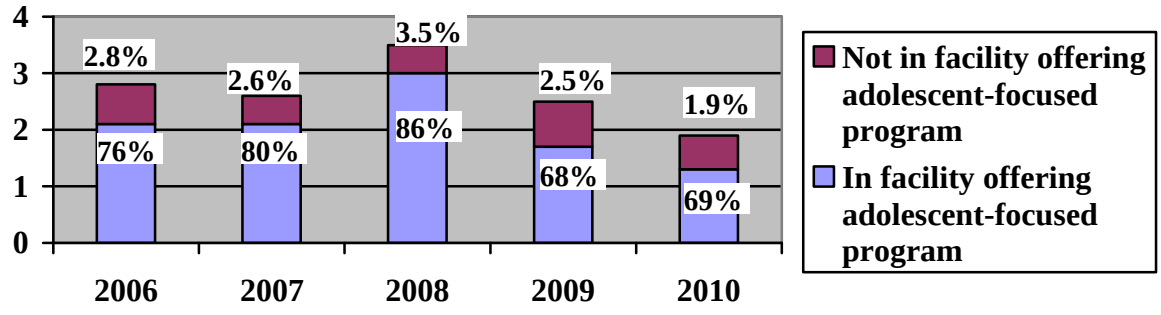
The data discussed below are the most recently available, from March 31, 2010, and pertain to Connecticut (except where otherwise noted). Committee staff anticipate conducting additional survey work to better understand the treatment services available and accessible to youth, with the results to be presented to the committee in the future.

Youth in care. Nearly two percent of those receiving treatment in Connecticut were under age 18 (adolescents);[32] data specific to other age groups, beyond "all adults," are not collected. The percentage of those in care who are adolescents has fluctuated over the past five years for which data are available, ranging from 3.5 percent in 2008 to 1.9 percent two years later. In Connecticut, adolescents have been a much smaller subset of those receiving treatment, than nationally (6.9 to 9.1 percent, in 2006 through 2010).

The vast majority (93.9 percent) of adolescents in 2010 were receiving outpatient treatment, with the remainder in non-hospital residential care. Nationally, a slightly higher percentage of adolescent clients are in residential care (11.4 percent in non-hospital care, and 1.5 percent in hospital inpatient care).

Data are not collected regarding if adolescents are in a program specific to their age; it is known only whether the facility at which they were receiving treatment offered such a program. There has been variation in the percentage of adolescents who are in facilities that offer special adolescent programs or groups, as shown in Figure I-2. In the past two years, however, the percentage has been relatively stable, at 68 to 69 percent. This is well below the national averages of about 81 percent in both 2009 and 2010. Nearly 14 percent of Connecticut facilities offered an adolescent-focused program or group, about half the rate nationally (29 percent).

Figure I-2. Percent of Connecticut Clients Who Were Adolescents (Under Age 18), and Whether Those Clients Were Receiving Treatment in a Facility that Offered an Adolescent-Focused Program, 2006-2010



Source: PRI staff calculations using N-SSATS data.

but the extent to which they do so is unknown. Solo practices might not be captured at all. Those providers who have requested inclusion in SAMHSA's online treatment locator are sent an N-SSATS survey, according to a June 15, 2012 committee staff conversation with DMHAS staff.

[32] The number of adolescents in treatment was 555.

Treatment facilities. There were 195 Connecticut treatment facilities participating in the 2010 survey; about 70 percent received public funds for substance abuse treatment. The total number of facilities has declined 9.7 percent from its recent-year peak of 216, in 2007. This contraction is more pronounced than the 3.1 percent national decline between 2006 and 2010.

Many facilities offer multiple levels of care, ranging from the most intensive (hospital inpatient) to different types of treatment provided on an outpatient basis. The overall percentages of Connecticut facilities offering the various levels in 2010 are shown in the table below.

Table I-2. Levels of Care Offered by Connecticut Substance Use Treatment Facilities, 2010

Level of Care/Setting	***Percent of Facilities Offering***
Hospital Inpatient	8.7
Detoxification	8.2
Treatment	6.2
Residential (non-hospital)	26.7
Detoxification	1.5
Long-term	20.0
Short-term	8.7
Outpatient	71.3
Detoxification	15.4
Day/evening treatment or partial hospitalization	15.4
Intensive	39.0
Regular	61.5
Methadone maintenance	15.9

Source: N-SSATS data. Accessed May 8, 2012 at: http://www.samhsa.gov/data/DASIS/sk10nssats/NSSATS2010Tbl6.6b.htm

Section II: Mental Health Parity Laws

What Are Mental Health Parity Laws?

The federal Mental Health Parity Act was established in 1996, with Connecticut adopting its own mental health parity law a year later. Both have since been substantially expanded.

The federal laws do not preempt state laws regarding mental health parity but create minimum requirements that no state may fall below. Any state is allowed to establish more rigorous requirements.[33] Thus mental health parity is difficult to define because there are many variations, but generally it means that a health plan's coverage for mental health conditions must be equal to its coverage for other health conditions. Some parity laws include a mandate that plans involve mental health coverage. Parity laws may encompass or exclude substance use treatment, which is one aspect of mental health care.

Table II-1. Comparison of the Connecticut and Federal Mental Health Parity Laws

	Connecticut	***Federal***
Included		
Mandate for coverage	✓	ACA*
Substance use disorder	✓	✓
Focuses on parity regarding:	Financial burden for enrollee	Quantitative (e.g., co-pays, visit limits) and non-quantitative (e.g., utilization review) treatment limitations
Applicable Plans		
Fully insured	✓	✓
Self-insured		✓
Group	✓	Large group only; also ACA*
Individual	✓	ACA*
Non-federal government employee		✓
Public health insurance	CHIP	Medicaid managed care, CHIP; also ACA*

*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 the text below), 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.

[33] Forty-nine states and the District of Columbia have some type of mental health parity law, according to the National Conference of State Legislatures. (http://www.ncsl.org/issues-research/health/mental-health-benefits-state-laws-mandating-or-re.aspx)

Table II-1 above compares the Connecticut and federal parity laws, which are most pertinent to this review. The chart shows that those laws vary in particular aspects, including the types of plans that must comply.

Connecticut parity laws. Advocates consider the state's current parity law, in effect since 2000, comprehensive because it:

- involves a wide range of mental health conditions, including substance use disorders; and
- does not exempt specific policy groups, have a cost increase opt-out, or financially limit requirements in any way.[34]

Importantly, the Connecticut parity law also mandates coverage: it requires a group or individual policy to cover mental or nervous conditions.[35] The law further prohibits the policy from including any provisions that place a greater financial burden on a plan enrollee for the diagnosis or treatment of those conditions compared to other, physical health conditions (C.G.S. Sec. 38a-488a(b) and 38a-514b).[36] Mental or nervous conditions are defined as 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 covered because it is listed in the DSM, at the stages of abuse and dependence.[37] Finally, the parity law requires a carrier to reimburse a range of specified licensed and certified health care providers, for mental health and substance use treatment.

The state parity law applies only to individual health plans and fully insured group health plans offered by HMOs and health insurers in this state, because the Connecticut Insurance Department does not regulate self-insured plans, public insurance plans, and a few other types.[38] Fully insured plans (group and individual) issued in Connecticut covered 1,094,789 enrollees in 2010.[39] The state parity legislation also extended to the children enrolled in HUSKY Part B (the Children's Health Insurance Program), who numbered 15,270 in State Fiscal Year 2011.[40]

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[34] "State Mental Health Parity Laws," National Alliance on Mental Illness. Accessed May 29, 2012 at: http://www.nami.org/Content/ContentGroups/Policy/Issues_Spotlights/Parity1/State_Parity_Chart_0709.pdf

[35] For health insurance policies that include coverage of: basic hospital expense; basic medical-surgical expense; major medical expense; and hospital or medical service plan contract.

[36] The law excludes six mental conditions: mental retardation; learning, motor skills, communication, and caffeine-related disorders; and relational problems.

[37] The DSM is under revision, with a new, fifth edition expected in 2013. The most recent draft version would expand the definition of a substance use problem, with the aim of making earlier intervention covered by insurance plans; see Section I for more information.

[38] Self-insured (also called self-funded) health plans are governed by federal law, the Employee Retirement Income Security Act (ERISA), which is enforced by the U.S. Department of Labor. Government and church plans that are self-insured do not fall under ERISA but need not comply with state mandates because they are self-funded.

[39] 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.

[40] "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

History. State mental health parity laws arose in the 1990s. Before then, it was common for plans to exclude, limit, or make more costly mental health coverage in comparison to medical/surgical coverage.

Connecticut's current parity law was put into place by P.A. 99-284, which replaced and expanded on a 1997 law that was part of a broader managed care regulation effort. The 1997 law granted parity to a limited number of mental conditions for enrollees of group and individual insurance policies, and did not extend to substance use disorders. Before the 1997 parity law, group insurance policies were required to minimally provide certain amounts of mental health inpatient and outpatient care, subject to a floor on annual benefits.

Federal parity laws. The most recent federal parity law, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343), provides some parity protections while differing from Connecticut's law in key ways. Federal mental health parity was expanded by the Patient Protection and Affordable Care Act of 2010, widely referred to as the ACA.

2008 parity law. The 2008 federal parity law forbids group health plans that offer mental health or substance use disorder benefits from imposing greater financial requirements or treatment limitations than exist for medical benefits. The requirements or restrictions placed on mental health or substance use care cannot be greater quantitatively (e.g., co-pays, visit limits) or qualitatively (e.g., medical management standards such as prior authorization or step-care).[41] Plans had to comply with the law starting in October 2009. The interim final rule, effective July 1, 2010, details certain applications of the law.

Unlike Connecticut's law, the 2008 federal law has no mandate for mental health coverage and does not cover individual policies. Further, a plan regulated by the law that experiences a small cost increase may apply for a one-year exemption.[42]

The law applies to plans and issuers of coverage for private and public sector employers with over 50 employees, regardless of whether the policies are fully insured or self-insured.[43] Approximately 59 percent of Connecticut's non-Medicare-eligible population is covered by an

[41] Under the interim final rule issued February 2, 2010: Financial and other quantitative requirements or limitations must be no more restrictive or burdensome that those for the "predominant" (at least one-half of) requirements or limitations applied to "substantially all" (at least two-thirds) of medical benefits, within six benefit classifications: inpatient in (1) and out (2) of network; outpatient in (3) and out (4) of network; emergency care; and prescription drugs. Non-quantitative limitations "must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors…with respect to medical surgical/benefits [sic] in the classification," except to "the extent that recognized clinically appropriate standards of care may permit a difference."

[42] A plan that experienced at least a two percent cost increase in the plan year beginning October 4, 2009, or a one percent increase any subsequent plan year, may apply for an exemption. A granted exemption is in effect for the following plan year, but then lapses. If the plan again experiences a one percent increase, a one-year exemption may again be sought. (Source: "The Mental Health Parity and Addiction Equity Act," The Center for Consumer Information & Insurance Oversight, Centers for Medicare & Medicaid Services (CMS). Accessed May 31, 2012 at: http://cciio.cms.gov/programs/protections/mhpaea/mhpaea_factsheet.html)

[43] Self-funded non-federal government plans with over 100 employees may elect to opt out. (Source: Ibid – CMS.)

employer-based health plan; it is unclear what portion is served by small employer plans and therefore lacks federal parity protections.[44] The federal law also applies to Medicaid managed care plans.

History. The 2008 federal parity law complements the federal Mental Health Parity Act of 1996 (P.L. 104-204), which requires parity for lifetime and annual dollar limits but not in any other way. The 1996 law excludes substance use disorder benefits, but its dollar limit protections now apply to them under the 2008 law.

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

- qualified health plans (as established by the ACA), which are among those that may be offered in (or out) of the state health plan exchanges;
- Medicaid non-managed care benchmark and benchmark-equivalent plans;[45] and
- new individual plans.[46]

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

These changes mainly result from the inclusion of mental health, substance use disorder, and behavioral health benefits as, collectively, one of the ten categories of essential health benefits. The essential health benefits package must be offered by insurers that offer new individual and small group plans, either within or outside the state exchanges, as well as by all Medicaid plans.[47] The exact services within the package's categories will vary among states and possibly even plans within a state.[48]

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[44] "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.

[45] It is unclear exactly how or even if the parity laws apply to these plans, for two reasons. First, the ACA appears to apply only those parity prohibitions against treatment limitations and financial requirements. Second, these plans are deemed to meet parity requirements if they offer Early Periodic Screening and Diagnostic Treatment (EPSDT) services, which by law they must do. (Source: Amanda K. Sarata, Congressional Research Service, "Mental Health Parity and the Patient Protection and Affordable Care Act of 2010." Accessed May 31, 2012 at: http://www.ncsl.org/documents/health/MHparity&mandates.pdf)

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

[47] "Essential Health Benefits: HHS Informational Bulletin," U.S. Department of Health and Human Services. Accessed May 31, 2012 at: http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html

[48] "Essential Health Benefits," Health Policy Brief, *Health Affairs*, April 25, 2012. Accessed May 31, 2012 at: http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=68. A state would have to pay for any "extra"

The ACA's essential health benefits provisions also ultimately prohibit spending limits for mental health and substance use disorder benefits, for any plan. Lifetime and annual insurer spending limits for any category within the package are to be removed, for plan years beginning September 2010 (unless grandfathered) and January 2014, respectively.[49]

The essential health benefits package and the exchanges aim to improve the depth and affordability of individual and small group plans, while reducing the percentage of those uninsured. In Connecticut, individual plans covered about five percent of the nonelderly population in 2009-10, while 13 percent were uninsured; the coverage under small group plans was unavailable.[50]

Oversight. The U.S. Department of Labor regulates self-insured group health plans, while the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) oversees non-federal governmental plans.

What Else, Regarding Health Plan Terms and Administration, Can Impact Access to Care for Mental Health and Substance Use Disorders?

Health benefit plans may manage access to covered care for any behavioral or medical condition through, among other techniques:

- using utilization review to determine whether requested or received treatment is or was "medically necessary," a process described in more detail in a following section;
- including cost-sharing, through coinsurance, co-pays and/or deductibles; and/or
- developing and maintaining a network of approved providers, with care outside the network often having either higher enrollee cost-sharing or no coverage at all.

Since the rise of managed care in the 1980s, these practices have been widely used by plans in an effort to contain costs and ensure enrollees receive appropriate care. The 2008 federal parity law requires that any care management tools *be used similarly* for mental health and substance use disorder care, and medical/surgical care. Connecticut's current parity law appears not to specifically address care management equality.

How Is Plan Compliance with the Mental Health Parity Laws Monitored?

The Connecticut Insurance Department's Life and Health Division is charged with reviewing policies under its jurisdiction (fully insured plans) for compliance with all laws,

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coverage required by state law in its essential health benefits package, for those enrolled in plans through the exchange.

[49] "Glossary: Essential Health Benefits," U.S. Department of Health and Human Services. Accessed May 31, 2012 at: http://www.healthcare.gov/glossary/e/essential.html

[50] "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

including state and federal mental health parity. Committee staff are in the process of researching this review process and its results.

Self-insured plans, which for large employers must comply with the federal parity law, are overseen by the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). EBSA receives and attempts to resolve enrollee complaints, informally and/or through investigation. In addition, plans are required to annually file a report with EBSA, which must be available to enrollees, and obtain an independent audit that may be randomly audited by the Administration.[51] Non-federal government plans are overseen by the Centers for Medicare and Medicaid Services (CMS). Committee staff will attempt to learn to what extent each federal agency reviews plans for parity compliance and receives parity-based complaints.

[51] "ERISA Enforcement," U.S. Department of Labor, Employee Benefits Security Administration. Accessed May 31, 2012 at: http://www.dol.gov/ebsa/erisa_enforcement.html

Section III: Utilization Review Background

What is Health Care Utilization Review?

The statutory definition of utilization review broadly encompasses a range of health care management techniques, but the most common use refers to the process by which a health carrier determines whether a requested or received treatment will be covered by the benefits plan.[52] The review frequently revolves around examining if the treatment is medically necessary. "Medical necessity" 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 C for the actual language.

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; or
- retrospectively, after treatment has been given.

Denial of coverage (for any reason) after utilization review is called an adverse determination. Appeals processes are available, as described below.

When is utilization review required?

Each health plan may require different types of utilization review, for varying categories of care. For example, a non-emergency inpatient or residential admission might require preauthorization, while a request for additional days of residential care could undergo concurrent review. A provider generally knows when utilization review is required and submits the request to the carrier.

Who conducts utilization review?

Utilization review is done by either the carrier or its contracted utilization review company or companies. A carrier can choose to "carve out" the review of a certain type of treatment, such as behavioral health, by using a utilization review company specializing in that area.

How is utilization review done, for plans regulated under state law (i.e., fully insured)?

Connecticut statute sets out required procedures, timelines, oversight, and other aspects of utilization review. Public Act (P.A.) 11-58 substantially changed the utilization review (and appeals) requirements, in part to bring the state into compliance with the federal Patient Protection and Affordable Care Act (ACA) reforms in the area. A few additional alterations, to

[52] C.G.S. Sec. 38a-591a

increase the information available to the enrollee and his/her advocate(s), made by P.A. 12-102 will become effective October 1, 2012.

Process. The initial review must be conducted by any licensed or certified health care practitioner. For a review of medical necessity, the practitioner must use the carrier's documented clinical review criteria, which are to be based on sound clinical evidence that is periodically reviewed. Consistent application of the criteria is to be actively overseen by the carrier.[53] The criteria are only guidelines, however, because a state's statutory definition of medical necessity is what must be followed in making the coverage determination, and that is done an on individualized basis. Decision timeframes vary based on the type of utilization review (e.g., prospective) and situation's urgency.

If an adverse determination is made, notice is sent to the enrollee and provider. The notice must include, among other components:

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

2. if the determination is based on medical necessity, either an explanation of the rationale applying the plan terms to the enrollee's situation, or a statement that a free copy would be provided upon request;[54]

3. a statement that all information relevant to the request and review are available free, upon request;[55] and

4. a description of the appeals process and right to contact the insurance commissioner or healthcare advocate, with contact information listed.[56]

A more thorough explanation of the process and the state laws that govern it will be provided by committee staff in a later report. Staff also will review the federal laws that apply to self-insured plans, as well as the relevant provisions of the ACA.

Companies. The Connecticut Insurance Department licenses and annually renews licensure of utilization review companies that conduct reviews for fully insured plans issued in the state. Minimum licensure requirements are set out in statute.[57]

[53] C.G.S. Sec. 38a-591c

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

[55] P.A. 12-102 changes the requirement to any materials regarding the case, and explicitly includes all documents, communications, information, and evidence, including medical journal citations. Timeframes for the information sharing are also set out.

[56] C.G.S. Sec. 38a-591d(e)

[57] C.G.S. Sec. 38a-591j

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

The 2011 legislation also narrowed the types of utilization review companies required to be licensed to only those that conduct reviews for fully insured health benefit plans, apparently in an effort to comply with the ACA.[58]

The insurance department's Market Conduct division annually surveys the utilization review companies for compliance with state requirements. Its surveys can indentify companies that need more intensive review, which in turn may result in sanctions. Information on this process and its consequences will be gathered by committee staff.

What is the appeals process, for plans regulated under state law (i.e., fully insured)?

An enrollee who receives an adverse determination may appeal the decision, first to the carrier directly, and failing that, to the insurance department.[59] These steps are called, respectively, internal and external appeals (i.e., reviews); expedited processes for both are available. Connecticut law mandates and sets requirements on internal and external appeals for fully insured plans. These appeals were successful for the enrollee about 48 percent of the time at the internal level[60] and 31 percent at the external level, in 2011.[61] Committee staff will attempt to collect data on utilization review and appeals results for treatment requests specific to this study's topic.

Internal appeal. For adverse determinations based on "medical necessity," the carrier must select a clinical peer not involved in the initial adverse determination for a review of the situation and a judgment of whether to reverse the decision.[62] A clinical peer, by law, is someone who is a licensed physician or other health care professional in "the same or similar specialty as typically manages the medical condition, procedure or treatment under review."[63] When the decision has been made, the enrollee is sent a notice that must have the same components regarding reason and criteria as the initial adverse determination notification, as well

[58] Previously all companies conducting utilization reviews – including reviews for self-funded and other non-fully-insured plans – were required to be licensed by the Connecticut Insurance Department.
[59] An external appeal is available when a carrier has denied, reduced, or ended coverage (or failed to pay) for several reasons: treatment not considered medically necessary (or related reason); treatment is experimental or investigational; individual is not eligible for the plan; or coverage has been rescinded due to alleged fraud (or related reason).
[60] "Report to Governor Dannel P. Malloy; Insurance and Real Estate Committee; Public Health Committee; Concerning the Regulation of Managed Care," Thomas B. Leonardi, Insurance Commissioner, March 1, 2012.
[61] PRI staff calculation using data from the Connecticut Insurance Department.
[62] Adverse determinations not based on medical necessity can be internally appealed but do not require review by a clinical peer (C.G.S. Sec. 38a-591f).
[63] C.G.S. Sec. 38a-591a(7)

as the steps to file an external appeal.[64] An insurer may require two internal appeals before an external appeal can be sought, except in urgent situations.

External appeal. The insurance department is the administrator of the external appeal process. In that capacity, it contracts with independent review organizations (IROs). IROs are not associated in any way with health plans or health care professional trade associations.[65]

Cases that meet the external review requirements (e.g., filed within 120 days of final adverse determination notice receipt) are sequentially assigned to one of the five IROs contracted for 2012 and 2013. The IRO clinical peer hears the appeal, reviews all documents, and makes the final decision. The statutory definition of "clinical peer" is stricter, for this level of review; the person must be:

- an expert in the treatment of the condition that is the subject;
- knowledgeable about the recommended treatment through recent or current clinical experience covering a person with the same or similar condition;
- licensed;
- without a history of disciplinary actions or sanctions; and
- free (along with the IRO) from a variety of conflicts of interest.[66]

How are utilization review and appeals handled and regulated, for plans regulated under federal law (e.g., self insured)?

While the Employee Retirement Income Security Act (ERISA) regulations adopted in 2003 provided for internal and external appeals processes for plans included under it, the Affordable Care Act more comprehensively addressed appeals. The ACA put in place certain requirements and extended the opportunity to appeal to virtually any enrollee.[67] Committee staff will research this area, as well as federal regulation of utilization review, during the next phase of the study.

[64] C.G.S. Sec. 38a-591e
[65] C.G.S. Sec. 38a-591l
[66] Sec. 38a-591l
[67] "Right to Health Insurance Appeals Process," National Conference of State Legislatures, February 2011. Accessed June 8, 2012 at: http://www.ncsl.org/documents/health/HRHealthInsurApp.pdf

Appendix A

Table A-1. Federal Data Sources on Youth Substance Use			
Source	***Agency****	***Participants***	***Weaknesses***
National Survey on Drug Use and Health (NSDUH)	HHS-SAMHSA	Age 12 and up	• State-level data are estimates only • Data lag (most recent state-level: 08-09 estimate)
Youth Risk Behavior Surveillance System (YRBSS)	CDC	Grades 9-12	• Out-of-school students not included • Middle school or earlier use not captured • Schools may opt out of survey • Administered every other year
Monitoring the Future Survey	NIH-NIDA	Separate surveys for: • Grades 8, 10, 12 • College students • Adults 19-50	• No state-level data • Out-of-school high school students not included
Treatment Episodes Data Set (TEDS)	HHS-SAMHSA	Treatment facilities	• Only includes those who were admitted to treatment • Might not include private-only facilities, or those without a state license • Counts episodes, so an individual may be represented more than once

*Agency abbreviations:
HHS-SAMHSA: U.S. Department of Health and Human Services – Substance Abuse and Mental Health Services Administration
CDC: Centers for Disease Control and Prevention
NIH-NIDA: National Institutes of Health – National Institute on Drug Abuse
Sources: PRI staff analysis and conversations with Connecticut children's behavioral health practitioners and a researcher

Appendix B

Table B-1. NIDA Principles of Effective Treatment

1. Addiction is a complex but treatable disease that affects brain function and behavior.
2. No single treatment is appropriate for everyone.
3. Treatment needs to be readily available.
4. Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.
5. Remaining in treatment for an adequate period of time is critical.
6. Counseling – individual and/or group – and other behavioral therapies are the most commonly used forms of drug abuse treatment.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.
9. Many drug-addicted individuals also have other mental disorders.
10. Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.
11. Treatment does not need to be voluntary to be effective.
12. Drug use during treatment must be monitored continuously, as lapses during treatment do occur.
13. Treatment programs should assess patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling to help patients modify or change behaviors that place them at risk of contracting or spreading infectious diseases.

Source: National Institute on Drug Abuse, National Institutes of Health Publication No. 09-4180, *Principles of Drug Addiction Treatment: A Research-Based Guide (Second Edition)*, April 2009. Accessed June 11, 2012: http://www.drugabuse.gov/publications/principles-drug-addiction-treatment

Appendix C

Statutory Definition of "Medical Necessity"

Formatting has been added, for ease of reading

C.G.S. Sec. 38a-482a and C.G.S. Sec. 38a-513c:… "Medically necessary" or "medical necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

(1) In accordance with generally accepted standards of medical practice; *[see below]*

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

(3) not primarily for the convenience of the patient, physician or other health care provider
and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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

Glossary

Adverse determination	Carrier or utilization review company decision to not cover or to limit coverage on requested or received services generally included under the health benefit plan
Carrier	Any entity subject to Connecticut's insurance laws that contracts to provide, deliver, arrange for, pay for, or reimburse health care costs (e.g., insurance company, managed care organization)
Clinical peer	For an internal appeal, a licensed health care professional in the same or similar specialty as typically manages the condition or treatment under review; for an external appeal, the clinical peer needs to have a higher level of expertise in the treatment for which coverage is being sought
Denial	*see "Adverse determination"*
Enrollee	A beneficiary of a health plan
External appeal (or review)	Upon an adverse determination and failed internal appeal(s), an enrollee who is fully insured or is on a state employee plan may request the Connecticut Insurance Department make a final decision on whether the adverse determination stands
Fully insured plan	Employer pays per-employee premium to insurer, which assumes the risk of providing coverage; usually used by smaller employers. Generally regulated at the state level.
Health benefits plan (or health plan)	An insurance policy or contract that involves the provision, delivery, or arrangement of health care costs or services. Excludes, by state statute, limited scope health benefits plans (e.g., dental, vision, hospital-only), for mental health parity and utilization review process laws.
Independent review organization	Organization with whom the Connecticut Insurance Department contracts to review and make a final decision on an external appeal; must be free of conflicts of interest
Internal appeal (or review)	Upon an adverse determination, an enrollee may request the carrier review and again decide whether / to what extent to extend coverage
Managed care plan/ organization	An arrangement between the insurer and a selected network of healthcare providers, with incentives for enrollees to use in-network providers; usually insurer takes formal steps to oversee type and quality of care. Examples: health maintenance organization (enrollees pay a fixed monthly fee regardless of amount of services received); preferred provider organization (providers / facilities provide services to a specific group or association, with fees based on services received); and point of service plan (no deductible and minimal co-payment for in-network services).
Mental health parity	Generally means that a health plan's coverage for mental health conditions must be equal to that for other health conditions; a parity law may include a requirement for mental health coverage within a

	plan (i.e., a mandate for coverage)
Plan	*see "Health benefits plan"*
Self-insured plan	Employer acts as its own insurer by directly paying health care claims to providers and bearing the risk, although may contract with insurer or another party to administer plan. Large employers often offer different types of plans with varied benefits and enrollee costs, to different types of workers. Generally regulated at the federal level, under ERISA.
Utilization review	In common use, process by which a health carrier determines whether and to what extent a requested or received treatment will be covered by the health plan

Acronyms

Not all of the following terms appear in the Update document; some are included because they may be used during the public hearing.

ACA	Patient Protection and Affordable Care Act of 2010
ASAM	American Society for Addiction Medicine
ASAM PPC-2R	*American Society for Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised* (i.e., the ASAM manual)
BHP	Behavioral Health Partnership (handles mental health, substance use, and other behavioral care for enrollees of all CT Medicaid programs, DCF Voluntary Services, and Charter Oak Health Plan)
CBT	Cognitive Behavioral Therapy
CDC	Centers for Disease Control and Prevention
DSM	*Diagnostic and Statistical Manual of Mental Disorders*
EBSA	Employee Benefits Security Administration (part of the U.S. D.O.L.)
ERISA	Employee Retirement Income Security Act
FFT	Functional Family Therapy
HHS	U.S. Department of Health and Human Services
IRO	Independent review organization
LIA	Medicaid for Low-Income Adults (replaced SAGA medical assistance in 2010)
MDFT	Multidimensional Family Therapy
MST	Multisystemic Therapy
N-SSATS	National Survey of Substance Abuse Treatment Services
NIDA	National Institute on Drug Abuse (part of NIH)
NIH	National Institutes of Health
NSDUH	National Survey on Drug Use and Health
SAGA	State-Administered General Assistance
SAMHSA	Substance Abuse and Mental Health Services Administration (part of HHS)
TEDS	Treatment Episode Data Set
UR	Utilization review
YRBSS	Youth Risk Behavior Surveillance System