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Testimony of Jamey Bell, Child Advocate,
In Support of
HB 6612*, AAC the Health Insurance Grievance Process for Adverse Determinations, the Office of the Healthcare Advocate and Mental Health Parity Compliance Checks*
Insurance and Real Estate Committee
March 12, 2013

Senator Crisco, Representative Megna, Senator Kelly, Representative Sampson, and distinguished members of the Insurance and Real Estate Committee: we appreciate the opportunity to testify before you today **in support of HB 6612.**

The mandate of the Office of the Child Advocate (OCA) includes undertaking legislative advocacy and supporting proposals for systemic reform, in order to secure the legal, civil and special rights of children who reside in this state.

The OCA supports strengthening the accessibility, responsiveness and quality assurance safeguards concerning mental health and substance use treatment within the health insurance system, especially as they affect the state's children. Mental health and substance use treatment services are essential for children and young adults' health and appropriate development; thus it is imperative that all systems related to the delivery of such services within the state operate in a manner which provides optimal accessibility, transparency and accountability. Reforms proposed in HB 6612 will provide a basic level of protection for families seeking mental health services.

The OCA knows firsthand the circumstances of children and young adults with mental health and substance use challenges through our numerous facility-based investigations concerning children in "the deepest end" of the state's child-serving system. Over 50% of the work we do—including responding to individual calls for assistance or information, and individual and systemic advocacy-- seeks to improve access to education, health and other state services for children, and to monitor the general child protection, educational and health system supports for children and families. Many of the children, adolescents and young adults with whom we work directly are either in hospitals or residential treatment facilities, committed to psychiatric hospitals, or incarcerated within the juvenile justice or adult corrections systems. Our unique access to information, people and places has allowed us to examine the details of their lives, revealing that too often these children have experienced neglect, abandonment, abuse, home and community violence and other traumatic events, educational challenges and/or mental health and substance use problems.

The OCA has significant experience investigating the circumstances of children with the most severe needs in the service delivery system—in residential facilities and hospitals which provide the most intensive, restrictive and expensive care-- whose life course may well have been changed if their special needs had been identified early and appropriate services provided within their home, community and school, which are the natural environments for all children and essential for their health and well being. Wise public policy dictates supporting a child's optimal social-emotional development from birth until adulthood.

Connecticut has invested extensively during the past several years in developing capacity within the **state-funded** children's and young adults' mental health systems. Many improvements have been made in the development of effective in-home and community based services for some of our most vulnerable children, youth and young adults. The OCA's work on behalf of children across state agencies, including DCF, DMHAS, DDS, DPH, and SDE, affirms that Connecticut's care of children has improved within all of these systems, yet substantial challenges remain. Children and young people seeking access to mental health and substance use services through the private insurance system experience even more frequent and serious barriers to accessing and receiving care than children in the state's insurance program (HUSKY).

For both publicly and privately insured children and young people, the current infrastructure is fragile and uneven. It is still reported regularly that:

- needed services are not readily available in parts of our state, too often causing exacerbation of the child's needs or a referral to inappropriate, but available, services;
- school systems are overwhelmed with students who are presenting with complex behavioral/emotional issues resulting in ineffective and dangerous interventions within the school, or suspension and expulsion of students; and
- our hospital emergency departments continue to experience extremely high and often disproportionate numbers of patients with complex mental health needs who spend days in the emergency department because of lack of appropriate resources in the community or other treatment facilities. This has the unfortunate consequence of diverting critically needed medical resources to other patients with potentially life-threatening conditions;
- families in need of services or supports across systems still face incredible challenges navigating the disparate systems.

It is imperative that we continue to support the progress already made, and ensure that identified gaps in services are filled, that children and young people and their families have timely access to services of the necessary type, intensity and duration. Too many Connecticut children struggling with mental illness currently cannot access mental health services when they need them due to persistent problems with capacity, availability and cost. Even individuals who have the ostensible benefit of insurance coverage for mental health treatment often have difficulty accessing appropriate treatment services. This problem is particularly serious for people with private health insurance, and is well documented in the investigative report of the Office of the Healthcare Advocate (OHA), "Findings and Recommendations: Access to Mental Health and Substance Use Services January 2, 2013".[i] At an OHA hearing in October 2012, numerous individuals testified regarding persistent problems with private insurance coverage. Services are denied, not authorized at the needed level of care or not allocated in ineffective time increments.

In addition to resulting in a lack of needed care for the individual, *inappropriate insurance coverage denials of needed mental health and substance use treatment can lead to inappropriate care-shifting and cost-shifting from the private sector to the public sector, which intensifies the access-to-care and financial crunch on the publicly funded health care side.* Enforcing and improving existing health insurance laws is an essential first step. OCA supports the following proposals:

1. Standard criteria across all mental health/substance use determinations

HB 6612 expands consumer protections by requiring that a standard and appropriate set of clinical criteria be used for all substance use and co-morbid utilization reviews. This recommendation was promoted by the Program Review and Investigations Committee's ("PRI") Study on Access to Substance Use Treatment for Insured Youth and the OHA hearing and report, which both found that mental health and substance use criteria used by some carriers for residential treatment utilization reviews did not match up well to professionally accepted standards, or include references to peer-reviewed literature or professional association guidelines that would justify the deviations.[ii]

By implementing a statutory requirement of recognized, standard mental health and substance use criteria, carriers, providers and, most importantly, consumers can know how treatment requests are to be assessed. More importantly, policyholders should have more predictable and consistent access to care across carriers. Using the widely accepted and clinically appropriate American Society for Addiction Medicine's Patient Placement Criteria, or alternate criteria approved by Department of Mental Health and Addiction Services and the Department of Children and Families, requests for treatment for substance use and associated co-morbidities will ensure that requests for services will be assessed with standard and clinically appropriate criteria by an experienced and clinically appropriate provider.

2. Faster turnaround time on urgent requests – a maximum of 24 hours, plus urgent requests automatically include mental health/substance use

The bill would require that prospective or concurrent utilization review requests involving treatment for a substance use or co-occurring disorder be treated as urgent care requests, as well as requiring that insurers complete the review process and issue a decision within twenty-four hours of the receipt of such a request instead of the current seventy-two hours. This reform acknowledges the clinical reality that, in these cases, delays in the onset of treatment may make the difference between recovery or relapse. HB 6612 also brings Connecticut into compliance with federal law. 29 CFR § 2560.503-1(f)(2)(ii)(B) requires that: "Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the plan administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments."

Individuals with substance use and addiction struggle on a daily basis, often complicated by an underlying co-occurring mental disorder. Delays in access to appropriate levels of care can not only impede a person's treatment, but could result in a rapid deterioration of any progress made, requiring a repeated or lengthened course of treatment and the additional costs associated with that care. Defining these requests as urgent care requests allows treatment decisions to be made in a timely and appropriate manner. The PRI study identified this as an important step to the removal of a clinically inappropriate barrier, stating that "*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*." [iii]

3. More robust uniform standards across all determinations for all provider types and specialized clinical peer for mental health/substance use

Connecticut's definition of "clinical peer" is inconsistent with surrounding states and undermines the protection of consumers who purchase insurance to cover medically necessary care. HB 6612 corrects this by ensuring that, for any adverse determination, the requested service or treatment and available clinical information has been reviewed by a clinician with training, experience and, where indicated, specialization relevant to the claim being reviewed. States surrounding Connecticut have more vigorous peer reviewer standards; e.g., Massachusetts[iv], Rhode Island[v] and New York[vi].

HB 6612 requires that clinical reviewers possess specific experience and training in age appropriate mental health and substance use treatment, recognizing that substance use and associated co-morbidities are unique diagnoses and deserve clinically appropriate consideration. The requirement that clinical reviewers for mental health and substance use conditions possess specialized training in the subject matter under review merely acknowledges the professional standards for specialization, and was an additional finding of the PRI study.[vii] For example, the American Academy of Child and Adolescent Psychiatry requires "two years of additional specialized training in psychiatric work with children, adolescents, and their families in an accredited residency in child and adolescent psychiatry."[viii] This clinical standard should be applied to standard utilization review processes, especially given the serious implications that improper decisions can have on policyholders, and the additional costs associated with inappropriate denials leading to repeated or lengthened treatments.

4. Notice to consumers of assistance available to them

As OHA is the federally designated consumer assistance program under the Affordable Care Act, denial notices should contain information about OHA's ability to assist consumers with grievances and appeals. Current law does not require denial notices to contain this information. HB 6612 corrects this deficiency in current law by enhancing the notice to consumers about free assistance available to them from OHA. HB 6612 also makes several minor modifications to OHA's statutes, clarifying OHA's role and scope of authority, as well as simplifying them.

5. Notices in writing

HB 6612 requires that all adverse determinations must be provided to the member in writing, with a detailed list of any criteria used in the utilization review process, as well as a detailed and

case specific explanation why the requested treatment or service was denied. This requirement is critical to ensuring that consumers receive adequate notice of, as well as to enhance their ability to understand, the basis for the denial. The OHA, based on its extensive experience with consumers, concludes that existing law does not provide the level of rationale that a policyholder should receive in order to understand the basis for the denial. Denials often generally cite criteria without providing specific information on the policyholders' circumstance that tie the criteria to the patient. Further, there is little evidence, according to the OHA's review of denial letters, that plans are in fact deferring to the statutory definition of medical necessity as the final arbiter of medical necessity, and instead are relying on their own criteria.

6. Ensuring mental health parity

The bill clarifies the Connecticut Insurance Department's ("CID") authority to specifically include routine assessments for carrier compliance with mental health parity laws (Mental Health Parity and Addiction Equity Act). This expands the protections available to consumers and codifies the common goal of serving consumers and enforcing existing law.

Thank you for the opportunity to provide testimony.

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[i] Office of the Healthcare Advocate, "Findings and Recommendations: Access to Mental Health and Substance Use Services" January 2, 2013
[ii] http://www.cga.ct.gov/pri/2012_atsu.asp
[iii] http://www.cga.ct.gov/pri/2012_atsu.asp
[iv] M.G.L. ch. 1760, § 12.
[v] R.I.G.L. § 23-17.12-9
[vi] Art. 49, Title 1, §4900
[vii] http://www.cga.ct.gov/pri/2012_atsu.asp
[viii] http://www.aacap.org/cs/root/facts_for_families/the_child_and_adolescent_psychiatrist