Review and Evaluation of Certain Health Benefit Mandates in Connecticut

2013

ADDENDUM

UCONN
Center for Public Health and Health Policy

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General Overview

Over the last 60 years, the Connecticut General Assembly has enacted numerous health insurance benefit mandates and limitations on health insurers licensed to sell insurance in Connecticut. In keeping with a growing trend among the states, the General Assembly in 2009 directed the Connecticut Insurance Department (CID) to review and evaluate both proposed and existing mandates, as requested by the co-chairs of the Insurance and Real Estate Committee of the General Assembly (P.A. 09-179). This statute directed CID to contract with the University of Connecticut Health Center, Center for Public Health and Health Policy (CPHHP) to perform such reviews, and authorized CID to recover the costs of such contract through assessments on the insurers. It also authorized the CPHHP to obtain whatever expertise it needed to perform the reviews, whether from inside or outside the university.

By a letter dated July 19, 2013, the co-chairs of the Insurance and Real Estate Committee (Committee) requested CID to report on four proposed health insurance benefit mandates. By agreement between CID and the co-chairs of the Committee, the deadline for the report on the first three mandates was December 31, 2013. However, the deadline for the report on the fourth mandate was extended to January 24, 2014. This document contains the report for the fourth mandate.

P.A. 09-179 detailed 25 issues to be addressed in the review of each mandate. These issues are divided into those which affect primarily the social impact of a mandate and those which affect primarily the financial impact, although a good deal of overlap exists among the two categories. Each section of this report addresses these issues for the respective proposed mandate. In addition, the background section describes the condition, services, equipment or supplies addressed by the mandate proposal, and the segment of the general population most affected by the condition, service, equipment or supplies.

Caveat: States only have the power to mandate health insurance benefits in fully insured products, which are regulated by the states as the business of insurance. Health plans provided by employers or organizations that do not purchase insurance policies to fund them are beyond the reach of state insurance regulation and are only subject to federal regulation under the Employee Retirement Income Security Act (so-called ERISA pre-emption). This is so even if the employer or group sponsor contracts with an insurance company to provide "administrative services only," because the employer retains the risk of funding the benefits itself and does not purchase insurance to fund the plan. So-called administrative services only (ASO) contracts are not considered insurance policies and therefore are not subject to state insurance regulation.

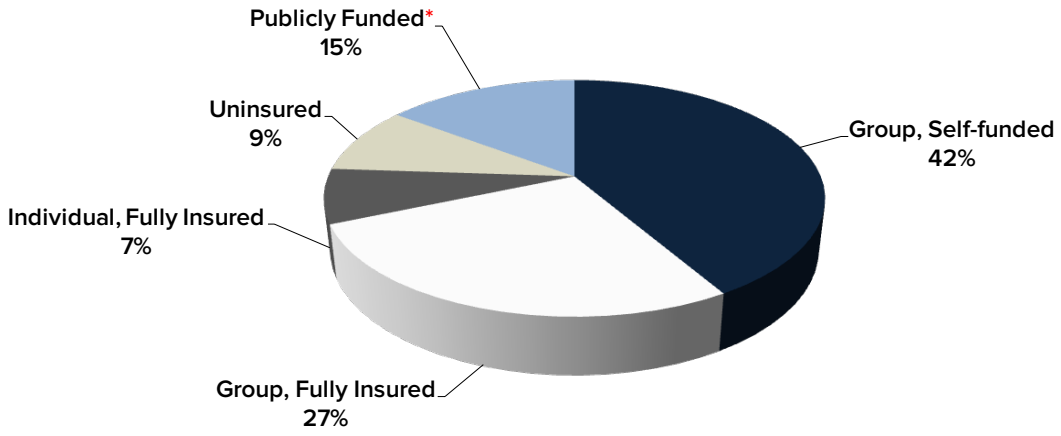
In 2014, the federal Patient Protection and Affordable Care Act (ACA) becomes applicable to small group and individual health insurance policies. The relationship of this law to state health insurance benefit mandates will be discussed in more detail below.

Health care coverage of Connecticut residents

In prior years, CID has estimated that approximately 50 percent of Connecticut's workforce is covered by fully insured health plans, and approximately 50 percent are covered by employer-funded health plans. CID has also expressed a concern that the trend is for more and more employers and organizations to opt for self-

funded plans, even relatively medium or small employers. This year the CPHHP's survey of Connecticut-domiciled insurers and managed care organizations found that self-funded health plans enrolled substantially more members than fully insured health plans in 2013. Thus, state benefit mandates may be applicable to an ever-shrinking number of Connecticut residents. The figure below shows the types of health care coverage for Connecticut residents.

Figure 1. Health Care Coverage for Connecticut Residents < 65 years old, 2012



*Publicly funded includes: Medicare, Medicaid, and Military health insurance plans

Source: Actuarial Report for the State of Connecticut on 2014 Health Insurance Mandates. OptumInsight. 2014. Split between group fully insured and self-funded based on: Oliver Wyman "*Annual tax on insurers allocated by state.*" November 2012

Optum's coverage estimate for 2012 (Figure 1) suggests that less than 35 percent of the population under age 65 had fully insured group or individual policies. Some of the fully insured are enrolled in plans/policies issued outside of Connecticut, for which state mandates may not apply.

Mandates

All of the proposed mandates in this report were introduced in the 2013 Session of the legislature. The letter from the Committee co-chairs referenced these bills and they form the basis of the analyses contained in the chapters. The proposed mandates for which the Insurance Committee requested review in 2013 are:

- Health insurance coverage for diagnosis and treatment of pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections, or PANDAS, as set forth in S.B. 956 from the 2013 Regular Session.
- Health insurance coverage for lung cancer screening when performed in accordance with the recommendations of the American Lung Association in consultation with the American Cancer Society, as set forth in S.B. 862 from the 2013 Regular Session.
- Health insurance coverage for fertility preservation services for insureds who face likely infertility as a result of a necessary medical procedure for the treatment of cancer or other medical conditions, as set forth in H.B. 5644 from the 2013 Regular Session.
- Health insurance coverage for treatment of mental and nervous conditions that are ordered by a court, similar to the language in S.B. 1091 from the 2013 Regular Session.

Process

Reviews of health insurance benefit mandates are a collaborative effort of CID and CPHHP, pursuant to a Memorandum of Agreement. The CID also contracts with the actuarial firm Optum to conduct an analysis of claims data related to the mandate. Optum was selected through a competitive bidding process managed by CID.

The CPHHP staff researched medical issues, including the conditions addressed by the proposed mandates, the available treatments for those conditions and the medical efficacy of the treatment addressed by the mandate. CPHHP also researched the existence of other types of coverage for the conditions addressed by the mandates, including mandates in other states, Medicare and Medicaid coverage, and programs of other units of state government and non-profit organizations. Optum performed the actuarial analysis and the economic analysis. Optum submitted a separate report which formed the basis for the premium and total dollar cost estimates included in each of the individual mandate reviews by CPHHP. Optum's full report is attached to this report as Appendix II.

Methodology

Center for Public Health and Health Policy

CPHHP staff conducted a search for published articles and other information related to the medical, social, economic and financial aspects of the required benefit. In addition, at the request of CPHHP staff, medical librarians at the Lyman Maynard Stowe Library at the University of Connecticut Health Center (UCHC) conducted searches using search terms particular to each proposed mandate. CPHHP staff consulted with clinical faculty and staff from the University of Connecticut School of Medicine and with outside medical providers on matters pertaining to medical standards of care, current and traditional practices, and evidence-based medicine related to the proposed benefits. Additional information was gathered through telephone and e-mail inquiries to appropriate state, federal, municipal, and non-profit entities and from internet sources such as the National Institutes of Health websites, the State of Connecticut website, Medicare website, other states' websites, and the websites of non-profit and community-based organizations.

CPHHP staff also surveyed six insurance companies and managed care organizations domiciled in Connecticut as to whether their fully insured group plans and individual policies currently included the proposed mandated benefit and for claims and enrollment data related to the proposed mandates. For the fourth mandate, CPHHP surveyed contracted service providers in collaboration with Court Support Services Division of the Judicial Branch.

Optum

CID contracted with Optum to provide actuarial and economic analyses of the proposed mandated benefit. Further details regarding the actuarial methods used to estimate the cost of the benefit and the economic methods used to estimate financial burden may be found in the Optum report (Appendix II). We recommend that the mandate reports be read in conjunction with this actuarial report for a more in-depth discussion of the issues addressed in those reports.

State employee health benefit plan

The reviews provide an estimated cost to the State employee health benefit plan for each mandate, including a calculation for those members of the retiree plans who do not participate in Medicare. These costs are based on the assumption that the State plan will continue to include all of the Connecticut mandated benefits, even though the State plan is now self-funded and does not purchase insurance policies that are

subject to state insurance mandates. It should be noted that the estimated cost to the State plan is calculated using the same cost calculations used for the fully insured population. The actual cost of the mandates to the State plan may be higher or lower, based on the actual benefit design of the State plan and the demographics of the covered lives (e.g., level of cost-sharing, average age of members, etc.).

Affordable Care Act[1]

Prior reports did not address the impact of the Affordable Care Act (Pub. L. 111-148 and Pub. L. 111-152) on the proposed mandate reviews. The Affordable Care Act (ACA) was not in effect at the time those reports were written and the regulations by which the act would be administered were still being developed. However, the ACA became effective on January 1, 2014, and will be in effect at the time any of these proposed mandates could be adopted by the Connecticut General Assembly. Therefore, this report includes a discussion of the interrelationship of the essential health benefits required in small group and individual health insurance policies after January 1, 2014 by the ACA and state-mandated insurance benefits.

The ACA and the final regulations promulgated under it[2] require all health insurance issuers that offer health insurance coverage in the small group and individual markets to include the "essential health benefits" package (EHB) as defined in the ACA.[3] This requirement applies to all individual and small group policies for plan years beginning on or after January 1, 2014, whether they are sold through the state's health insurance exchange or outside of it. For the plan years 2014 and 2015, EHB are determined in a given state by the selection of a benchmark plan in the state that reflects the scope of services provided by typical employer plans. For Connecticut, this is the ConnecticutCare HMO plan, with supplemental coverages for pediatric dental and vision care as required by ACA.

States are free to require policies issued through the exchange to cover benefits in addition to EHB, but the states are required to defray the cost of such additional state-required benefits either directly to the enrollee or to the plan issuer on behalf of the enrollee.[4] This applies only to policies issued through the exchange, whether or not they are subsidized plans. State-required benefits that were enacted on or before December 31, 2011 are deemed not to be in addition to EHB pursuant to HHS regulation. State-required benefits enacted after that date are deemed to be in addition to EHB.[5]

The definition of "state-required benefits" for the purpose of this regulation is narrower than P.A. 09-179's definition of "mandated benefit." "State-required benefit" is interpreted by HHS to include the care, treatment and services that an issuer must provide to its enrollees. It does not include requirements to cover specific types of providers or service delivery methods (these are included in P.A. 09-179's definition of mandated benefit). The state exchange is responsible for determining whether a state-required benefit is in excess of EHB, and the policy issuers are responsible for determining the cost attributable to an excess state-required benefit.

The definition of "small group plan" in the ACA also differs between the ACA and Connecticut law. Under the ACA, "small group" is 1-100 employees. Connecticut law defines a small group plan as 1-50 employees.

1 For an in-depth discussion of this topic, see California Health Benefits Review Program (CHBRP), (2013). *California state benefit mandates and the Affordable Care Act's essential health benefits*. Oakland, CA: CHBRP.

2 Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value and Accreditation; Final Rule. Federal Register, 78 no. 37, p12834. Accessed December 22, 2013 from: http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.

3 ACA Section 1302(a).

4 ACA Section 1311(d)(3)(B).

5 45 CFR part 155, section 170.

For the 2014 and 2015 plan years, the ACA permits states to apply their own definitions of small group. However, for plan years beginning in 2016 and beyond the ACA definition must be applied. This may increase the potential liability of the state for defraying the costs of excess state-required benefits, because larger groups may become insured through the exchange. Additionally, for plan years beginning in 2017 the states may permit issuers to offer large group plans through their exchanges, with the potential to further increase the state's exposure under this section.

These provisions of the ACA should be kept in mind when considering proposed benefit mandates.

ADDENDUM

Treatment that is Ordered by a Court for Mental Disorders

A Report to the Insurance and Real Estate Subcommittee
of the Connecticut General Assembly

Analysis of Senate Bill 1091:

"Treatment that is Ordered by a Court for Mental Disorders."

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I. Overview

On July 19, 2013, the Chairs of the Insurance and Real Estate Committee of the Connecticut General Assembly (the Committee) directed the Connecticut Insurance Department (CID) to review four proposed health insurance benefit mandates. Analyses of three of these proposed mandates were submitted to the CID on December 31, 2013. This report contains the analysis of the fourth proposed mandate, as presented in Senate Bill No.1091 from the 2013 Regular Session. It should be read in conjunction with the earlier report, in particular the sections of the General Overview that describe the sources of health insurance for Connecticut residents and the impact of the federal Affordable Care Act on state required benefits.

This report follows the requirements stipulated under Public Act 09-179, An Act Concerning Reviews of Health Insurance Benefits Mandated in this State. Reviews of required health insurance benefits are a collaborative effort of the CID and the University of Connecticut Center for Public Health and Health Policy (CPHHP).

S.B. 1091 provided for the establishment of a task force "to study health insurance coverage of and program enrollment options for treatment that is ordered by a court for mental disorders." Although the referenced bill deals with the establishment of a task force to study the issue, with the agreement of the CID, this report evaluates the financial and social impact of a mandate to require fully insured group and individual health insurance policies to cover treatment that is ordered by a court for mental disorders.

CPHHP made the following assumptions to guide its evaluation of this proposed mandate:

1. For purposes of this review, "mental disorders" is assumed to be defined in the same way as "mental or nervous condition" is defined in C.G.S.A. §§38a-488a and 38a-514.
2. The proposed mandate does not contemplate an expansion of covered services for carriers. The proposed mandate would simply clarify that otherwise-covered services cannot be excluded or denied under the policy because they are ordered by a court or as part of a judicial proceeding.
3. Carriers will be able to apply other policy criteria, such as medical necessity and utilization review, to court-ordered services.
4. Carriers will be able to apply any policy limits that apply to the same services when provided in non-judicial circumstances, regardless of the duration of services that are ordered by the court or as part of a judicial proceeding. (For example, if a policy provides coverage for a maximum of 30 days for a particular service, this is the maximum that the carrier could be required to cover, even if the court ordered a longer duration.)
5. Carriers will be able to negotiate rates with providers for these services.
6. Probate Court orders for involuntary commitment, involuntary medication and electroconvulsive therapy are considered to be in scope for the proposed mandate.
7. Services for persons remanded by the courts to the Department of Correction or to the Connecticut Juvenile Training School are not included in the scope of the proposed mandate.
8. Pursuant to these assumptions, court orders for services that would not typically be covered under a health insurance policy were not included in this review.

Data Collection

Several approaches to data collection were pursued in this investigation. CPHHP staff fielded a survey to six health insurance carriers domiciled in Connecticut, as described in the Methods section below. Additionally, CPHHP staff obtained data from the Court Support Services Division (CSSD) of the Judicial Branch, the Department of Mental Health and Addiction Services (DMHAS), the Department of Children and Families (DCF), and the Office of the Probate Court Administrator (concerning mental health commitments and services permitted by the courts). CPHHP staff also fielded a survey to mental health and substance abuse treatment providers that are under contract with CSSD to provide court-ordered services.

The CID also contracted with the firm OPTUMInsight (Optum) to conduct an actuarial analysis of commercial claims data for the mandate. The Optum analysis estimates the 2014 per member per month (PMPM) cost for the benefit under fully insured group and individual plans.

Utilization and cost data were very difficult to obtain through primary data collection. The carriers uniformly stated that they do not maintain records on whether a covered service has been ordered by a court. The state agencies do not keep records as to whether a client has private insurance coverage. In addition, in many instances, program services included both covered services and non-covered services and it was difficult to separate the utilization figures for the two categories. The survey to the CSSD contract providers indicated that the providers do bill private insurance carriers, where a client has private insurance, and do collect benefits from the carriers, but that only a limited percentage of clients have private insurance.

Existing health insurance coverage

Five carriers of six responded to the survey questions related to this proposed mandate. For their fully insured policies, all five carriers indicated that mental health services that 1) are otherwise covered by the policy, 2) meet the medical necessity criteria of the carrier, and 3) are provided by licensed mental health providers, are covered irrespective of whether they were ordered by a court. One carrier stated that any policy exclusion for court-ordered treatments applies only to treatments that are deemed to be not medically necessary or that are otherwise outside the scope of covered benefits. One carrier required the court order to specify that the client's private insurance carrier was responsible for the cost of the court-ordered service in order for there to be coverage under the policy. All carriers emphasized their right to independently determine the medical necessity of any mental health treatment that is ordered by a court (Medicaid takes a similar position on medical necessity).

Self-funded plans: The percentage of Connecticut residents covered by self-funded plans who have coverage for court-ordered treatments for mental disorders could not be determined.

Estimated 2014 premium

Group policies: Based on 2011 and 2012 year claims data, the actuarial report projects the estimated paid medical cost for court-ordered treatment for mental disorders in 2014 at $0.374 per member per month (PMPM). This estimate represents the total paid medical cost. The total premium impact when including medical cost, administrative fees, risk factor, and profit or surplus is projected to be $0.44 PMPM, which is 0.09 % of the estimated total premium for group plans. However, it is unclear from the agency and the carrier responses whether this would be new cost. Please see the answer to question number three in the Social Impact section below.

Individual policies: Based on 2011 and 2012 year claims data, the actuarial report projects the estimated paid medical cost for court-ordered treatment for mental disorders in 2014 at $0.30 per member per month (PMPM). This estimate represents the total paid medical cost. The total premium impact when including medical cost, administrative fees, risk factor, and profit or surplus is projected to be $0.345 PMPM, which is

0.11 % of the estimated total premium for individual policies. Again, it is unclear from the agency and the carrier responses whether this would be new cost.

This report is intended to be read in conjunction with the General Overview to the December 31, 2013 report and the Optum Actuarial Report which is included as Appendix II.

II. Background

Epidemiology of Mental Disorders and Treatment Need

Psychiatric and substance use disorders are common in the U.S. About one-half of U.S. adults living in the community meet criteria for any lifetime psychiatric or substance use disorder, with first onset typically occurring during childhood or adolescence.[6] Similarly, about one-half of U.S. adolescents (13 to 17 years of age) in the community have some diagnosable psychiatric or substance use disorder.[7] These rates are even higher among the justice-involved population. In a study of past year psychiatric symptoms among adults (18 to 65 years), 27% of people who had been on probation and 17% of non-probationers had symptoms of a mental disorder.[8] In a longitudinal study of pre-sentence juvenile detainees (10 to 18 years), 62% of males and 65% of females met criteria for some psychiatric or substance use disorder in the preceding six months at baseline interview.[9] At a five-year follow-up interview, 45% of males and 30% of females met criteria for some disorder and had associated impairment.[9] Notably, about two-thirds of these study subjects were living in the community at the five year follow-up while about 30% resided in correctional facilities. Thus, while psychiatric and substance use disorders are common in the community, they are even more common among justice-involved people of all ages.

While scholars and clinicians alike widely agree that treatment for psychiatric and substance use disorders can be effective, challenges must be overcome to realize benefits. First, access to care is a potential barrier, often measured by the presence or absence of health insurance. In one national study, people with serious mental illness (SMI) were more likely to be uninsured than a group with less serious mental illness and a group with no known mental illness.[10] The proportions of uninsured were 20%, 18% and 11%, respectively. Furthermore, the SMI group was least likely to have private insurance coverage (35%). However, the SMI group was most likely to have public insurance, with 38% covered by either Medicaid or Medicare. Second, health care services utilization is needed. The study on SMI and insurance discussed directly above also examined past year psychiatric services utilization rates by insurance variables. Findings revealed that having any type of health insurance significantly increased the odds of a person with SMI utilizing specialty services.[10]

There is a dearth of scholarship about individual and clinical characteristics and insurance statuses for people

6 Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication.(vol 62, pg 593, 2005). *Arch. Gen. Psychiatry.* Jul 2005;62(7):768-768.

7 Merikangas KR, He J-p, State agencies, Medicaid, Medicare or private insurance carriers already pay treatment costs for court-ordered mental health and substance use disorder treatments. M, et al. Lifetime Prevalence of Mental Disorders in U.S. Adolescents: Results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*. 2010;49(10):980-989.

8 Crilly JF, Caine ED, Lamberti JS, Brown T, Friedman B. Mental health services use and symptom prevalence in a cohort of adults on probation. *Psychiatr Serv.* Apr 2009;60(4):542-544.

9 Teplin LA, Welty LJ, Abram KM, Dulcan MK, Washburn JJ. Prevalence and Persistence of Psychiatric Disorders in Youth After Detention. *Arch. Gen. Psychiatry.* Oct 2012;69(10):1031-1043.

10 McAlpine DD, Mechanic D. Utilization of specialty mental health care among persons with severe mental illness: the roles of demographics, need, insurance, and risk. *Health Services Research* Apr 2000;35(1 Pt 2):277-292.

under court orders for mental health or substance use disorder treatment. The studies reviewed report on populations that likely have some overlap with the population that would be affected by the current mandate, but they are by no means representative of the population with which we are currently concerned. Therefore caution must be exercised when generalizing the above estimates to the population that would be affected by the current mandate. Knowledgeable leadership at key state agencies consistently told CPHHP staff that a very small proportion (i.e. 10% or less) of individuals under court orders for treatment for mental disorders in Connecticut have private insurance coverage. This estimate was further supported by contracted provider responses to an original survey fielded by CPHHP (detailed below). In sum, while existing estimates in the scholarly literature of the prevalence of psychiatric disorder, available insurance and health care utilization may set upper and lower limits on what we would expect for people under court orders, targeted study of the court ordered population is needed to have confidence in estimates of these important considerations. The estimated impact of the proposed mandate on health insurance premiums has therefore been calculated using the assumption that 10% of clients served by CSSD programs have private insurance, as reported by CSSD's contracted providers. (It should be noted that the portion of clients who have fully insured health insurance is likely smaller than ten percent.)

Pathways to Treatment through the Courts

The power of the state judicial system is sometimes leveraged to pressure individuals to engage in mental health or substance use/abuse treatment. Mandated treatment manifests in a variety of forms (outlined below) and can occur in various stages of criminal justice system involvement. While some offenders are offered mandated treatment in lieu of prosecution, others receive court orders to participate in treatment during sentencing and still others are required to engage in treatment as a condition of probation following a period of incarceration.

In the State of Connecticut, the Superior Court is one of two courts that may issue an order for psychiatric or substance use treatment. Under the category of Special Sessions, the Drug Intervention Program is designed for non-violent, addicted offenders and includes frequent court monitoring as well as drug testing, detoxification, and intensive inpatient or outpatient treatment, typically ordered for 12 to 15 months.[11] For offenders suspected of requiring inpatient treatment, a dependence evaluation is conducted by one of three provider organizations contracted with the judicial branch who together maintain 16 treatment beds. Typically, these referrals will result in inpatient stays. Thus, the costs of both the evaluation and treatment are covered under this contract. Outpatient treatment is more varied, though the cost of evaluation and services is frequently covered by CSSD.

In terms of programs, the Supervised Diversionary Program is designed for offenders with psychiatric disabilities. If an offender meets eligibility criteria, he or she is first referred to CSSD which confirms eligibility and recommends the type(s) of community supervision, treatment and services needed. If the court then grants the program application, the defendant is again referred to CSSD which places him or her into programs and services. CSSD typically covers the cost of treatment. Another pertinent diversion program is the Alcohol Education Program. This program is designed for people charged with operating a motor vehicle or boat while under the influence of alcohol. After individuals are evaluated by both CSSD and DMHAS, DMHAS may recommend a treatment program (see DMHAS response to CPHHP request for information in Appendix IV). The cost of the treatment is to be paid by the defendant, though the court may waive this requirement. When the payment requirement is waived or if the defendant has no health insurance, it is unclear whether CSSD, DMHAS or some other state agency covers the cost of treatment. The Drug Education Program design parallels the Alcohol Education Program, though it is targeted at defendants charged with violating drug possession or drug paraphernalia laws. The Superior Court also runs the "Treatment of Offenders who are Dependent on Drugs or Alcohol Instead of Prosecuting Them"

11 Superior Court Criminal Division. A Guide to Special Sessions & Diversionary Programs in Connecticut. Hartford, Connecticut. 2012.

program. This program is for addicted defendants who are charged with drug sale or possession offenses. The court may order a substance dependence evaluation, presumably through CSSD, as well as treatment. In each of these diversion programs, if a defendant successfully completes mandated treatment, the court may decide to dismiss the charges.

The Superior Court includes both adult and juvenile courts. Juvenile courts may also order psychological and other mental health assessment in child protection cases as well as delinquency proceedings. The juvenile courts maintain a network of approved licensed clinicians who perform these assessments. It is our understanding that court-orders for treatment issued by the juvenile court are administered by CSSD in collaboration with DCF, with some high-level services provided directly by DCF.

In addition to the Superior Court, the Probate Courts may order treatment via a mental health or substance use inpatient commitment. In the case of Civil Commitment for Treatment of Psychiatric Disability, the process is initiated by a petitioner (e.g., family member) alleging that the individual is a harm to him/herself or others or is gravely disabled. An attorney is then appointed and two doctors perform evaluations. If the evaluations determine that psychiatric disability is present, the individual may be involuntarily committed to a hospital. A civil commitment may last for as few as 15 days, though it can last as long as the individual remains disabled, which may be months or even years. Typically, the inpatient stay is for 30-60 days. During the hospital stay, clinical staff may seek permission from the court for "treatment against will." Specifically, permission may be sought for involuntary medication administration or electroconvulsive therapy (ECT) when a person refuses needed treatment or is incapable of providing informed consent. The costs of involuntary treatment administered during civil commitment are bundled within the price of a bed day. Similar to the psychiatric commitment procedure, Substance Abuse Commitments are initiated by a concerned person who petitions the court. A hearing is held where evidence is presented about the person's condition with testimony from the person as well as qualified health professionals. If the probate judge decides that inpatient services are needed, the person may be committed to an inpatient facility for as few as five days for detoxification under the Physician's Emergency Commitment (PEC) status, though he or she may stay for 30 or more days.

Programs and Services Available for Court-Ordered Mental Disorders in Connecticut

A variety of programs and services are available in community and inpatient settings to satisfy court orders for treatment. In all cases, when the defendant has public or private health insurance, the treatment provider is expected to seek reimbursement from these sources first. When the individual lacks public and private health insurance, the cost of treatment is typically covered by one or more state agency/agencies. Treatment programs are typically administered through individual providers or provider organizations that contract with CSSD, DMHAS or DCF. Table 1 presents those programs and services thought to be pertinent to the proposed insurance mandate by key informants at CSSD, DMHAS, probate court and DCF after consultation with CPHHP staff. CPHHP staff considered programs and services to be in-scope if they are: 1) ordered by a court, 2) are of a clinical nature, 3) are delivered by a licensed clinician, and 4) their purpose is not primarily or fully forensic in nature (e.g. the information will be used for criminal justice system purposes, as opposed to primarily for clinical purposes). In Table 1, programs and services presented in red text were judged to not be relevant to the proposed mandate by CPHHP staff. Key informants at each agency also provided data on the number of clients served annually in some of the programs and services (utilization figures were not obtained for some programs/services and assumptions were made for these), which is presented in the final column of Table 1. Numbers of clients served annually in programs deemed to be out of scope are not presented. In these cases, the "Clients/Year" column is populated with "N/A" (not applicable). Where CPHHP staff were unable to obtain yearly utilization numbers for in-scope programs, this column is populated with "NULL." For three programs operated by CSSD for juveniles (MST, MDFT, and MDFT CRP), utilization numbers were not provided. Instead CPHHP staff reasoned that the 800

cases that received court-based assessments would be distributed across these programs, with higher intensity services serving fewer patients. Programs are presented by agency and the age group for which they were designed.

Table 1. Programs and Services by Agency 2012[12,13]

Agency (Age Group)	**Program or Service**	**Brief Description**	**Clients/Year**
CSSD[14] (Adult)	Adult Behavioral Health Services (ABHS)[15]	Integrated substance abuse and mental health evaluations; substance abuse, mental health, anger management and relapse preventions groups; intensive outpatient treatment, individual treatment, substance abuse testing, medication evaluations and medication management.	13,901
CSSD (Juvenile)	Multi-systemic Therapy (MST)	An intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behaviors including substance abuse in juvenile offenders.	400[16]
	Multidimensional Family Therapy (MDFT)	A family-based, comprehensive treatment system for adolescent drug abuse and related behavioral and emotional problems.	300[16]
	Multidimensional Family Therapy Community Residential Program (MDFT CRP)	A staff secure four-month therapeutic residential program that incorporates Multidimensional Family Therapy. Serves 11-17 year-olds on juvenile probation and on a case by case basis 17 year-olds on adult probation or involved with Bail. All clients must be returned home after their stay at this program and in-home services start within two weeks of the intake. In-home services are provided throughout the client's residential stay and up to 6 months after discharge. Referrals can have substance abuse histories and often have a mental health diagnosis. On-site education, medical mental health and recreational services are provided. Off-campus activities are provided under staff supervision.	100[16]
	Court-Based Assessments (CBA)	Evaluation by contracted licensed mental health evaluators (Psychiatrists, Psychologists, Clinical Social Workers) as ordered by Superior Court for Juvenile Matters. Evaluations include Psychiatric, Psychological, Substance Abuse and Psycho-sexual.	800

12 Refers to calendar year, unless otherwise noted.

13 Out-of-scope programs and services are indicated in red text. No utilization numbers are provided for these programs and services.

14 CSSD = Court Support Services Division.

15 Because components of ABHS were deemed out-of-scope, the number of clients per year served in this program is likely inflated for current purposes.

16 Utilization numbers based on the assumption that the 800 evaluations will all be referred to one of three programs, with the highest intensity program serving the fewest clients and the lowest intensity program service the most

Agency (Age Group)	**Program or Service**	**Brief Description**	**Clients/Year**
CSSD (Juvenile)	Juvenile Sex Offender Services (JSOS)	Age-appropriate, comprehensive, and multifaceted treatment. Utilizes a collaborative, multi-systems approach involving all stakeholders.	N/A
DMHAS[17] (Adult)	Competency to stand trial – restoration		N/A
	Competency to stand trial – not competent, not restorable (?) (NCNR)		N/A
	Substance Dependence –Evaluation		Included in Treatment
	Substance Dependence – Treatment (inpatient)		59
	Psychiatric Security Review Board (PSRB) 60 day evaluation	PSRB is an independent state agency statutorily mandated to protect the public through the oversight of persons found not guilty by reason of mental defect or disease (NGRI or Not Guilty by Reason of Insanity). Determines the level of supervision, treatment and placement of an acquittee required to protect the public. Six board members, appointed by the Governor, receive a $75 honorary per diem.	N/A
	Psychiatric Security Review Board (PSRB) WFD (?)		N/A
	Psychiatric Security Review Board (PSRB) OP (outpatient evaluation?)		N/A
	General pre-trial requirement for treatment		N/A
	Probation requirement for treatment		NULL
Probate[18] (Adult)	Involuntary Commitment		1,088
	Electroconvulsive Therapy (ECT)		122
	Forced Medication		302
DCF[19, 20] (Juvenile)	Court-Ordered Evaluation		665
		Total	**17,737**

As displayed in Table 1, programs and services ultimately judged to be pertinent to the mandate under consideration ranged from very high intensity services (e.g. electroconvulsive therapy and/or forced psychiatric medication during a period of involuntary inpatient commitment) to relatively low intensity services (e.g. psychiatric and addictions evaluations, group therapy). Together, at least 17,737 court-ordered referrals were received by in-scope programs and services in 2012. This number is likely an underestimate, as CPHHP was unable to obtain utilization numbers for four of the twelve programs considered to be in scope. However, the annual utilization number for CSSD's Adult Behavioral Services program is likely inflated because three components of the program (anger management, relapse prevention, substance abuse testing) were deemed to be out of scope and CPHHP was unable to obtain utilization numbers that differentiated among the various component services.

17 DMHAS = Department of Mental Health and Addiction Services.

18 Figure is for fiscal year 2013.

19 DCF = Department of Children and Families.

20 Figure is for fiscal year 2013.

III. Methods

The methods used to evaluate the financial and social impact of implementing S.B. 1091 included a literature review, web-based research, telephone inquiries, key informant interviews, surveys of Connecticut-domiciled carriers, data provided by the Court Support Services Division of the Judicial Branch and the Department of Mental Health and Addiction Services, and findings from actuarial and economic analyses conducted by Optum. The CPHHP staff conducted a search for published articles and other information related to the medical, social, economic and financial aspects of the required benefit. In addition, CPHHP staff conducted reviews of scholarly articles identified through systematic reviews of relevant scholarly databases containing published studies within allied disciplines.

CPHHP staff also used in-person, telephone and e-mail inquiries to appropriate state, federal, municipal, and non-profit entities and searched internet sources such as the Centers for Medicare and Medicaid Services (CMS) website, other states' websites, and non-profit and community-based organization websites. Also, the CPHHP research team consulted with faculty and staff from the University of Connecticut's School of Medicine on matters pertaining to medical standards of care, traditional, current and emerging practices, evidence-based medicine related to the benefit, treatment cost and utilization.

CPHHP staff fielded a survey to six carriers domiciled in Connecticut. The six carriers surveyed account for 90 percent of covered lives in the Connecticut-domiciled fully insured group market and 94 percent of covered lives in the Connecticut-domiciled individual market. The survey requested policy documents (e.g., utilization review processes, parameters for defining medical necessity, etc.) and data for the proportion of members with policy exclusions, the extent of member coverage, treatments requested and approved, and claims related to mental health treatment ordered by a court, as specified by the mandate. All carriers responded; however, the completeness and quality of responses varied.

CPHHP also surveyed psychiatric and substance use disorder providers who are contracted with CSSD. The details of this survey immediately follow.

Survey of CSSD Contracted Providers

Background on Survey Design and Data Collection Process

As described in the Background section above, CSSD is often central in overseeing the provision of programs and services that are court-ordered. According to its website, CSSD:

> "…oversees pre-trial services, family services, divorce and domestic violence, probation supervision of adults and juveniles as well as juvenile residential centers including Juvenile Detention. CSSD also administers a network of statewide contracted community providers that deliver treatment and other support services." (http://www.jud.ct.gov/cssd/).

CPHHP staff first met with CSSD's Director and leadership staff to learn more about processes and the types of services that may be in scope for this mandate. In addition, CPHHP staff sought to learn about the capability of data systems for providing in scope utilization numbers, associated costs, and sources of payment for services (with particular interest in insurance status and type). CPHHP learned that, in July 2013, CSSD implemented a procedure for its vendors to report program income and expenditures on a monthly basis. The expectation was that once this was incorporated into vendors' standards of practice, then reliable information would be routinely collected on program income and expenditures. This will include the monthly dollar figure collected from private insurance carriers and other payers for each program. However, this new procedure was not designed to capture the numbers of clients served with particular sources of payment. Because core data elements for the current mandate review were not readily available,

CPHHP designed an original data collection effort in close collaboration with CSSD. This took the form of a survey of CSSD providers. The survey instrument is attached as Appendix III.

CSSD provided a contact list of Executive Directors in its provider network to CPHHP. CPHHP staff scheduled and conducted phone interviews with leadership in two of the largest CSSD provider organizations to learn about data system capabilities and the types of relevant information that would be available. In addition, CPHHP sought to learn about in-house expertise to assemble the requested data elements, as well as the expected turnaround time following a request. Through these phone interviews and conversations with CSSD staff, CPHHP determined that there is wide variation in size, service portfolio, data collection procedures, data systems, staff expertise (to assemble data) and anticipated staff burden across provider organizations. Based on this information, the decision was made to design survey questions at the macro level and to limit the number of questions to the minimal necessary in order to reduce response burden on provider organizations and to increase the odds of receiving an adequate response rate.

The survey contained eighteen questions plus two open-ended optional questions, allowing respondents to describe capabilities and limitations of their data systems as well as any additional thoughts or comments. An email invitation to complete the online survey was sent to leadership at fifty-seven CSSD contracted provider organizations by CPHHP on November 12, 2013. An email clarifying the specific programs and services that CSSD deemed to be in scope (see Table 1) was sent on behalf of CSSD on November 17, 2013. Two reminder emails were sent roughly one week apart. The online survey closed at 5:00 p.m. on Friday, November 29, 2013. Thus, the survey was active for 17 calendar days.

Response Rate and Data Quality

After accounting for organizations indicating that their programs are out of scope, opting out and invitations that bounced back due to invalid email addresses, the adjusted response rate for completing any portion of the survey was 17% (8/46). Due to the low response rate, incomplete, and inaccurate data, utilization numbers presented in this report were not obtained from the provider survey, but rather from CSSD program area leadership and/or assumtions reasoned with input from Optum. Similarly, the costs of programs and services did not originate from the provider survey, but rather from commercial claims data (see Optum report, Appendix II).

Select Findings

Despite survey data limitations, some conclusions can be drawn from the survey. First, as expected based on conversations with CSSD staff and Executive Directors or assigned proxy respondents of two large provider organizations, responding CSSD providers vary widely in their scale and service portfolio. Among eight respondents providing data on some portion of the survey, the number of CSSD clients served in FY 2012 ranged from 86 to 3,078. The proportion of juvenile CSSD clients served ranged from 0% to 75% (n=7). The proportion of CSSD clients treated for substance use disorder ranged from 20% to 96% (n=8) and the range served for mental disorder (excluding substance use) ranged from 4% to 75% (n=8). Second, responding providers support the conclusion gleaned from interviews with key stakeholders that a very low proportion of CSSD clients have private insurance coverage. When asked about the proportion of adult clients who had private insurance, responses ranged from 0% to 25% (n=7). Notably, the 25% response is an outlier on the high end with the next highest response being 16% and the remainder being 12% or lower. When asked about the proportion of juvenile clients served with private insurance, responses ranged from 0% to 50%, with the modal response being 0% (n=7). Here again, the highest response appears to be an outlier with the balance of responses all being below 10%. As stated above, based in part on these findings, the estimated impact of the proposed mandate on health insurance premiums has been calculated using the empirically supported assumption that 10% of individuals in court ordered treatment have private insurance coverage. Finally, half of the responding providers collect some reimbursements from private insurance

carriers for CSSD client services in FY 2012. The amount collected from private insurance carriers in FY 2012 ranged from $0 to $193,413, with four respondents indicating that no reimbursements were collected. The total amount collected from private insurance carriers for CSSD client services was $366,649 across the four responding providers that collect any reimbursements. However, a CSSD report provided indicates that a total of $946,118 was collected from private insurance carriers in FY 2012 across a broader array of providers. However, an unknown portion of these dollars may have been collected for services that would be out of scope for the current mandate.

IV. Social Impact

1. The extent to which the treatment, service or equipment, supplies or drugs, as applicable, is utilized by a significant portion of the population.

The services and treatments that would be covered by this proposed mandate are only those that are ordered by a court. This includes the various divisions of the Superior Court and the Probate Courts. Data provided by CSSD, DMHAS, DCF and the Office of the Probate Court Administrator indicate that at least 17,737 people per year receive court orders for treatment for mental or nervous conditions that could be covered by private insurance policies.

2. The extent to which coverage for court-ordered mental health or substance use disorder services are available to the population, including, but not limited to, coverage under Medicare, or through public programs administered by charities, public schools, the Department of Public Health, municipal health departments or health districts, or the Department of Social Services.

Court Support Services Division of the Judicial Branch (CSSD): CSSD is the primary provider of mental health and substance use disorder services that are ordered by the Connecticut courts. CSSD contracts with private providers and collaborates with DMHAS and DCF to provide these services. CSSD gets an annual appropriation from the Legislature for the costs of these programs, as part of the budget for the Judicial Branch. The contract providers are expected to bill Medicaid and private insurance carriers for their services, where such coverage is available for an individual participant. CSSD then reimburses the contract providers for contract expenses that are not covered by Medicaid or private insurance. In some cases, CSSD also pays the cost-share of the individual client. A few CSSD programs require non-indigent participants to pay a fee, but these programs generally provide services that are not typically covered by health insurance policies and are not considered to be in scope for this mandate.

Interviews with CSSD staff indicated that very few court-ordered individuals have private insurance, but where there is private insurance, contract providers are expected to bill the carrier for the services that are covered by the policy. The provider survey indicated that roughly one half of providers (assuming survey respondents were representative of all providers), do in fact bill private insurance for their services and do collect some reimbursement. However, a very small percentage of the participants in their programs have private insurance. Many more have publicly funded insurance, which is billed for covered services. CSSD, or some other state entity, pays the providers for the unreimbursed portion of their fees and individual participants are not billed for these amounts.

The Department of Mental Health and Addiction Services (DMHAS): DMHAS provides both inpatient and outpatient mental health and addiction services to individuals pursuant to court orders. It operates Connecticut Valley Hospital (CVH,) the state's principle forensic, general psychiatric and addictions

inpatient treatment facility. DMHAS also has a Division of Forensic Services[21] whose purpose is to provide and coordinate mental health and substance use disorder services to individuals who become involved with the criminal justice system. The services of this division run the gamut from maximum-security inpatient beds at the Whiting Forensic Division of CVH to community crisis intervention teams to alcohol and substance abuse educational and treatment programs in the community. DMHAS mental health clinicians are also present in the criminal court houses as liaisons to the courts.

This Forensic Services Division collaborates with the Court Support Services Division of the Judicial Branch on a number of jail diversion programs for individuals with mental health or substance use disorders who become involved with the criminal justice system in Connecticut.[22] Medicaid is billed for many of these services, where it is applicable. Non-indigent individuals are responsible for the costs of some services, which could be billed to their insurance policies.

Department of Children and Families (DCF): DCF Juvenile Services provides and funds services annually to approximately 1,300 delinquent children and youth. In addition to collaborating with CSSD on programs for children referred from the juvenile courts, DCF also contracts for a variety of juvenile justice programs and services – both residential and community based.[23] These services may include behavioral health treatment, education, vocational programming, and therapeutic recreation. Only the behavioral health treatment is likely to be covered by a private health insurance policy.

Probate Court: Connecticut probate courts have the authority to order individuals to be involuntarily committed to mental health institutions and substance use disorder treatment programs. They also have the power to order placement in a hospital for the purposes of involuntary medication or electroconvulsive therapy.[24] Such orders generally are issued only after a hearing at which medical evidence is presented. In the case of involuntary commitment, two physicians must examined the individual. Probate courts do not provide funding for such commitments or for mental health or substance use disorder treatments which are provided during the commitments.

Medicare: Medicare covers court-mandated treatment and services for mental disorders and substance abuse.[25] In regards to coverage, Medicare affirms, "It doesn't matter if the treatment is court-ordered or not, as long as the doctor or provider deems it medically necessary, Medicare will cover the treatment. If the doctor or provider does not deem it medically necessary Medicare will not cover it."[26] Also, in order for the coverage to be effective, the treatment and services must be "provided by a qualified doctor, clinical psychologist, clinical social worker, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant in a doctor or other health care provider's office or hospital outpatient department."[27]

Public Programs Administered by Charities: Many hospitals may also provide services and treatments to court-referred individuals for mental health disorders and substance abuse, though the fees vary by entity;

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21 Department of Mental Health and Addiction Services. Forensics Services Division. Accessed on January 15, 2014 from: http://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=334746.

22 Department of Mental Health and Addiction Services. Community Forensic Services. Accessed on January 15, 2014 from: http://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=334748.

23 Department of Children and Families. DCF Programs and Services Descriptions. Accessed on January 15, 2014 from: http://www.ct.gov/dcf/cwp/view.asp?a=2556&q=314386#Juvenile_Justice.

24 Connecticut Probate Courts. Mental Health Commitments. Accessed on January 15, 2014 from: http://www.ctprobate.gov/Pages/Civil-Commitments.aspx.

25 Personal Communication. Gwen Jenkins, Customer Service for Medicare and Medicaid Services, September 26, 2013.

26 Personal Communication. Dana Black, Customer Service for Medicare and Medicaid Services, October 10, 2013.

27 U.S. Department of Health and Human Services. Centers for Medicare and Medicaid Services. What Medicare Covers, Mental Health Care (Outpatient), Accessed October 10, 2013 from: http://www.medicare.gov/coverage/outpatient-mental-health-care.html#1368.

some offer a sliding scale, while others have set fee.[28, 29] In some cases, non-profit behavioral health centers and clinics offer a sliding scale for mental health and substance use disorder treatment that includes mental health evaluation and treatment services. Many of these organizations also offer evaluations and treatment for court-referred patients.

Public Programs Administered by Public Schools: An investigation of the Connecticut Department of Education, municipal and regional boards of education, and additional web-based inquiries found no information indicating public schools fund or directly provide treatment that is ordered by a court for mental disorders or drug addiction.

The Department of Public Health (DPH): CPHHP researchers did not find evidence suggesting DPH funds or directly provides treatment that is ordered by a court for mental disorders or drug addiction.

Municipal Health Departments or Health Districts: None of the seven municipal health departments and sixteen local health districts responding to a phone and web-based inquiry reported providing funding and/or directly providing treatment for court-mandated treatment of mental disorders and drug addiction.

The Department of Social Services (DSS): According to DSS, "A court order does not override medical necessity requirements, so court-ordered services are not automatically covered by Medicaid. However, if a Medicaid-eligible individual is court-ordered for treatment and that treatment is deemed medically necessary, ordered by a physician/APRN and is a Medicaid covered service, we would pay for it." [30] The cost for these treatments and services can be found in the Provider Fee Schedule.[31, 32]

Other: Some municipalities such as the Town of Branford and the Town of Newington have counseling centers and accept court referrals for mental health and/or substance abuse. Certain patients may be eligible for a sliding scale fee.[33, 34]

3. The extent to which insurance coverage is already available for the treatment, service or equipment, supplies or drugs, as applicable.

Many of the treatments, services, supplies and pharmaceuticals that would be covered by the proposed mandate are already required to be included in fully insured health policies pursuant to other statutory provisions. Five of the six carriers that were surveyed reported to CPHHP that they currently cover mental health and substance use disorder treatment if it is medically necessary, is otherwise covered by the policy, and is provided by licensed medical providers, irrespective of whether it is ordered by a court. Some of the carriers indicated that their policies may have exclusions for court-ordered mental health and substance use disorder claims, but said that these exclusions only apply if the services do not meet the carrier's medical necessity criteria, are otherwise not covered by the policy or are not provided by licensed medical providers. The written policy of one carrier appears to require that the court order specify that the carrier is responsible

28 Connecticut 211 Infoline, Mental Health, Norwalk Hospital and Connecticut Valley Hospital, Program Details, Accessed on September 26, 2013 from: http://www.211ct.org/referweb/Detail.aspx?c;;0;;;0;1905110;15508917;24377;3;MENTAL HEALTH CARE; Central Intake, Assessment & Referral Services;186;Mental Health Evaluation * Court Ordered Individuals; True.

29 Department of Mental Health and Addiction Services, Connecticut Valley Hospital, Admission, Treatments, and Discharges. Accessed on September 26, 2013 from: http://www.ct.gov/dmhas/cwp/view.asp?a=3519&q=417324.

30 Personal Communication, Barbara Fletcher, DSS Medical Policy & Regulations Unit. September 27, 2013

31 DSS Provider Fee Schedule: Behavioral Health, 2013

32 DSS Provider Fee Schedule: Ambulatory Detoxification, 2013

33 Town of Branford, Counseling Center, Substance Abuse Services; accessed on September 26, 2013 from: http://www.branford-ct.gov/counseling.htm.

34 Town of Newington, Human Services, Social Work. Accessed on September 26, 2013 from: http://www.newingtonct.gov/content/78/118/132/3131.aspx.

for the cost of the court-ordered treatment. Policy requirements for pre-certification of some services may also apply.

However, the Office of the Health Care Advocate (OHA) testified at the public hearing on S.B. 1091 that "…we have found that, in many cases, what would be a covered service under a member's commercial plan is denied solely because it was court ordered, irrespective of any subsequent clinical affirmation." It is not clear whether the commercial plans referred to by the OHA were fully insured plans that would be subject to this proposed mandate, or were self-funded plans that would not be subject to the mandate.

4. If the coverage is not generally available, the extent to which such lack of coverage results in persons being unable to obtain necessary health care treatment.

These are publicly funded programs, for the most part, and lack of insurance coverage does not prevent persons from obtaining court-ordered services. Discussions with personnel at the Court Support Services Division of the Judicial Branch confirmed that CSSD pays for whatever Superior Court-ordered services are not covered by private insurance or Medicaid.

5. If the coverage is not generally available, the extent to which such a lack of coverage results in unreasonable financial hardships on those persons needing treatment.

There is no evidence that persons who are ordered into mental health treatment by the Superior Courts suffer a financial hardship in obtaining such treatment. Discussions with personnel at the Court Support Services Division of the Judicial Branch confirmed that CSSD pays for whatever court-ordered services are not covered by private insurance or Medicaid.

According to Senate Floor testimony, the issue was not the costs borne by the recipient for court-ordered mental health treatment, but the cost that is shifted to the state when insurance companies deny court-ordered treatment for individuals.[35, 36]

However, Probate Court orders for inpatient commitment can be costly. Commitments may be to DMHAS or to private hospitals. If not covered by insurance, the cost of such commitments can pose a significant burden to the individual needing treatment or to the state.

6. The level of public demand and the level of demand from providers for court-mandated mental health and substance use disorder treatments.

CSSD provided data indicating that it provides programming for at least 17,737 court referrals annually for mental health or substance use disorder treatment. As discussed above, the services are generally reimbursed by the CSSD if there is no private insurance or Medicaid.

No health care providers or members of the general public provided testimony for or against S.B. 1091.

7. The level of public demand and the demand from providers for the insurance coverage of court-mandated mental health and drug addiction treatments.

No providers or members of the general public provided testimony about insurance coverage for court-

35 Sen. Martin Looney (11th District). Quote from: Connecticut General Assembly. Session Year 2013. Senate Floor Testimony on S.B. 1091 "An Act Establishing A Task Force To Study Health Insurance Coverage of and Program Enrollment Options for Treatment That Is Ordered by a Court for Mental Disorders" (Date 5/08/2013). Accessed September 10, 2013.

36 Public Hearing on S.B. 1091. Conn. Joint Standing Committee Hearings, Insurance and Real Estate, 2013 Sess., testimony submitted by Vicky Veltri, Office of the Healthcare Advocate, March 12, 2013. Accessed on January 17, 2014 from: http://www.cga.ct.gov/2013/INSdata/Tmy/2013SB-01091-R000312-Victoria%20Veltri,%20State%20Healthcare%20Advocate-TMY.PDF.

ordered treatment for mental conditions. Although the carriers reported to CPHHP that they cover mental health and substance use disorder treatment if it is medically necessary irrespective of whether it is ordered by a court, the OHA testified that "we have found that, in many cases, what would be a covered service under a member's commercial plan is denied solely because it was court ordered, irrespective of any subsequent clinical affirmation." [37] It is not clear whether the commercial plans referred to by the OHA were fully insured plans that would be subject to this proposed mandate, or were self-funded plans that would not be subject to the mandate.

Public hearing testimonies are not necessarily representative of whether or not the general public or broader health care provider community supports insurance coverage for all procedures and purposes described in the mandate language.

8. The likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states.

The National Association of Insurance Commissioners (NAIC) maintains a database of health benefit mandates and the states in which they were enacted. As of September 5, 2013, the NAIC database showed no states as having enacted a health benefit mandate referencing court-ordered treatment.[38]

9. The relevant findings of state agencies or other appropriate public organizations relating to the social impact of the mandated health benefit.

Thirty states require a fiscal note or an additional review process for any new required health insurance benefit prior to enactment.[39] In reviewing the archives of the states with these processes, no analyses of a proposed or enacted health benefit mandate for covering court-ordered treatment were identified. According to the NAIC database, no states have enacted a health benefit mandate referencing court-ordered treatment.[40]

During discussions with CPHHP staff, state agency personnel indicated that their contractors do experience denials of coverage from insurance carriers from time to time; however, it was not clear whether these coverage denials were based soley on the fact that treatment had been ordered by a court. The carriers, as well as Medicaid and Medicare, reserve the right to make determinations of medical necessity on each claim submission and also require that the services provided be otherwise covered by their policies.

It was also not clear whether the commercial plans referred to by the providers were fully insured plans that would be subject to this proposed mandate, or were self-funded plans that would not be subject to the mandate.

10. The alternatives to meeting the identified need, including but not limited to, other treatments, methods or procedures.

Many of the treatments and services are covered by other health insurance benefit mandates, including C.G.S.A. §§38a-488a and 38a-514. Most Connecticut-domiciled carriers state that they do cover medically necessary mental health and substance use disorder services, to the extent the policy provides, irrespective of whether the services have been ordered by a court.

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37 Ibid.

38 National Association of Insurance Commissioners. Compendium of State Laws on Insurance Topics – Individual Chart. August, 2011.

39 California Health Benefits Review Program. Other States' Health Benefit Review Programs, 2011. Accessed January 17, 2014 from: http://www.chbrp.org/other_publications/docs/other_states_health_benefits2011.pdf.

40 National Association of Insurance Commissioners. Compendium of State Laws on Insurance Topics – Individual Chart. August, 2011.

11. Whether the benefit is a medical or broader social need and whether it is consistent with the role of health insurance and the concept of managed care.

The services which are included in the proposed mandate are medical services. Statutory provisions already require inclusion of most services. The proposed mandate focuses on the entity that orders the services, clarifying that services ordered by a court are to be covered in the same manner as services ordered by medical professionals. It appears that court orders for treatment are generally made in conjunction with the professional opinion of licensed medical practitioners. Most Connecticut-domiciled carriers state that they do cover services ordered by a court, so long as they meet the other criteria of the policy; namely, that they are medically necessary, provided by a licensed medical professional and otherwise covered by the policy.

12. The potential social implications of the coverage with respect to the direct or specific creation of a comparable mandated benefit for similar diseases, illnesses, or conditions.

This proposed mandate could be compared to the mandate for fully insured health policies to cover medically necessary early intervention services[41] provided by qualified personnel pursuant to an individualized family service plan under the Connecticut Birth to Three program (C.G.S.A.§17a-248d). The early intervention mandate also requires insurance policies to provide coverage for services that would otherwise be covered by the State.

13. The impact of the benefit on the availability of other benefits currently offered.

The PMPM cost attributable to this mandate is unlikely to affect the availability of other benefits in itself. It is unclear whether it represents new cost to the plans. Many of the carriers say they already cover mental health and substance use disorder services in their fully insured policies if the services otherwise meet the coverage requirements of their policies and are deemed to be medically necessary.

14. The impact of the benefit as it relates to employers shifting to self-insured plans and the extent to which the benefit is currently being offered by employers with self-insured plans.

The PMPM cost attributable to this mandate is unlikely to affect the shift of employers from fully insured to self-funded plans. Many of the carriers say they already cover court-ordered mental health and substance use disorder services in their fully insured policies if the services otherwise meet the coverage requirements of their policies and are deemed to be medically necessary.

15. The impact of making the benefit applicable to the state employee health insurance or health benefits plan.

According to the state Comptroller's Office, in 2012 there were 161,368 covered lives in the state employee health insurance plan under the age of 65.

Connecticut transitioned to a self-funded plan on July 1, 2010. Therefore, it does not currently purchase a fully insured policy that is subject to state health insurance benefit mandate laws. Often, however, the State Plan agrees to cover health insurance benefits similar to those described in the mandates.

Current language in the State of Connecticut Health Benefit Plan states: "The Plan does not cover court-ordered services or services that have been ordered as a condition of probation or parole. However, these services may be covered if the Carrier agrees that they are Medically Necessary, are otherwise covered, and the Participant has not exhausted any benefit limit for the Calendar Year, and the treatment is provided in

41 C.G.S.A.§§38a-490a and 38a-516a.15.

accordance with the Carrier's policies and procedures."[42]

Because this language is permissive, the cost of court-ordered mental health and substance use disorder treatment may, at least in part, be new cost to the State Plan.

Assuming that the State Plan does not currently cover court-ordered mental health treatment, but that it would comply with this mandated health benefit, the total annual cost to the State Plan for this mandate in 2014 is estimated to be $723,984. This has been calculated by multiplying the 2014 PMPM cost by 12 to get an annual cost per insured life, and then multiplying that product by 161,368 covered lives. To the extent that the State Plan currently does pay for some court-ordered mental health or substance use disorder treatment under the permissive language quoted above, this new cost would be reduced.

Caveat: This estimate is calculated using the estimated weighted average developed by Optum in its report for this proposed mandate. The actual cost of this mandate to the State plans may be higher or lower, based on the actual benefit design of the State plans and the demographics of the covered lives (e.g., level of cost-sharing, average age of members, etc.).

16. The extent to which credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community determines the treatment, service or equipment, supplies or drugs, as applicable, to be safe and effective.

This mandate deals primarily with the issue of whether the state or private insurance pays for court-ordered treatment. It is not specific to any particular treatment or service. Presumably, any service or treatment to which it would apply would also be subject to a review for medical necessity, which takes into account safety and effectiveness.

V. Financial Impact

1. The extent to which the mandated health benefit may increase or decrease the cost of psychiatric or substance use disorder treatment over the next five years.

The mandate is not expected to materially alter the availability or cost of court-ordered mental health or substance use disorder treatment over the next five years. According to the carrier survey, the benefit is included in most fully insured group and individual health insurance plans and in Medicaid and Medicare. The presence of the insurance mandate is not expected to have any additional effect on its cost.

2. The extent to which the mandated health benefit may increase the appropriate or inappropriate use of court-ordered mental health or substance use disorder treatment over the next five years.

This proposed mandate is not expected to increase or decrease the use of such care over the next five years.

3. The extent to which the mandated health benefit may serve as an alternative for more expensive or less expensive treatment, service or equipment, supplies or drugs, as applicable.

This question is not applicable to this proposed mandate. S.B. 1091 does not address any specific mental health or substance use disorder treatment.

42 Office of the State Comptroller. State of Connecticut Health Benefit Plan. Accessed on January 17, 2014 from: http://www.osc.ct.gov/benefits/docs/Medical%20Plan.Document.July1.2013.final.pdf.

4. The methods that will be implemented to manage the utilization and costs of the mandated health benefit.

It is anticipated that carriers will implement the same utilization management methods and cost controls that are used for other covered benefits. The legislation does not prohibit carriers from reviewing a claim for medical necessity or from employing utilization management, prior authorization, or other utilization tools at their discretion.

5. The extent to which insurance coverage for court ordered treatment for mental disorders may be reasonably expected to increase or decrease the insurance premiums and administrative expenses for policyholders.

Insurance premiums include medical cost and retention costs. Medical cost accounts for medical services. Retention costs include administrative cost and profit (for for-profit insurers/MCOs) or contribution to surplus (for not-for-profit insurers/MCOs).

Group and Individual policies: The total effect on insurance premiums from S.B. 1091 is estimated at $0.00 PMPM for carriers that say they already provide such coverage in their fully insured policies. It is expected that the paid medical claims already incorporated into their 2014 premiums for fully insured group health plans will contribute an estimated $0.044 PMPM or $0.53 per year per member. For fully insured plans that do not currently include such coverage, this mandate would add that amount to premium.

For further discussion, please see the Optum Actuarial Report in Appendix II.

6. The extent to which the treatment, service or equipment, supplies or drugs, as applicable, is more or less expensive than an existing treatment, service or equipment, supplies or drugs, as applicable, that is determined to be equally safe and effective by credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.

This question is not applicable to this proposed mandate. S.B. 1091 does not address any specific mental health or substance use disorder treatment.

7. The impact of insurance coverage for treatment for mental disorders on the total cost of health care, including potential benefits or savings to insurers and employers resulting from prevention or early detection of disease or illness related to such coverage.

The total cost of health care is understood to be the funds flowing into the medical system, which are the medical costs portion of insurance premiums and cost sharing. There would be no new costs flowing into the medical system as a result of this proposed mandate. This mandate seeks only to shift costs that are already paid by the state to private insurance coverage.

8. The impact of the mandated health care benefit on the cost of health care for small employers, as defined in section 38a-564 of the general statutes, and for employers other than small employers.

No published literature was found regarding the effect of mandated coverage of court-ordered mental health and substance use disorder treatment on the cost of health care for small employers.

In general, if the premium increases, the employer may decide to absorb that cost or increase the employee's share of the premium. Alternatively, a potential premium increase can trigger a decision to redesign benefits. If benefits are redesigned, coverage for some non-mandated benefits may be discontinued. Firms may also increase employee cost-sharing at the point of service level with increased co-payments or deductibles. To

some degree, both the employer and the employee are sensitive to increasing prices and small businesses tend to be more sensitive to price changes than large businesses.

For further information regarding the differential effect of the mandates on small group versus large group insurance, please see the Optum Actuarial Report in Appendix II.

9. The impact of the mandated health benefit on cost-shifting between private and public payers of health care coverage and on the overall cost of the health care delivery system in the state.

Cost-shifting between private and public payers of health care coverage generally occurs when formerly privately insured persons, after enrolling in a public program or becoming un- or underinsured, require and are provided health care services. Cost-shifting also occurs when a formerly publicly-funded service becomes the responsibility of private payers, which can result following enactment of a health insurance mandate. The primary impact of S.B. 1091 would be to shift some costs now paid by the state to private insurance.

The overall cost of the health delivery system in the state is understood to include total insurance premiums (medical costs and retention) and cost sharing. The 2014 projection for the overall cost to the health care delivery system for the coverage of court-ordered treatment for mental disorders for the population covered by fully insured group and individual health policies is estimated to be $5,111,556, which is total annual premium. This may or may not be new cost, to the extent that fully insured policies already cover such services. State agencies, Medicaid, Medicare or private insurance carriers already pay treatment costs for court-ordered mental health and substance use disorder treatments.

For further information, please see the Optum Actuarial Report in Appendix II.

Also see discussion of the impact of the Affordable Care Act on new state-required benefits in the General Overview section.

Appendix I

Connecticut General Assembly Bill Evaluated in this Report

- Senate Bill 1091

General Assembly

Raised Bill No. 1091

January Session, 2013

LCO No. **4034**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT ESTABLISHING A TASK FORCE TO STUDY HEALTH INSURANCE COVERAGE OF AND PROGRAM ENROLLMENT OPTIONS FOR TREATMENT THAT IS ORDERED BY A COURT FOR MENTAL DISORDERS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (*Effective from passage*) (a) There is established a task force to study health insurance coverage of and program enrollment options for treatment that is ordered by a court for mental disorders.

(b) The task force shall consist of the following members:

(1) Two appointed by the speaker of the House of Representatives;

(2) Two appointed by the president pro tempore of the Senate;

(3) One appointed by the majority leader of the House of Representatives;

(4) One appointed by the majority leader of the Senate;

(5) One appointed by the minority leader of the House of

Representatives;

(6) One appointed by the minority leader of the Senate; and

(7) The Insurance Commissioner, the Healthcare Advocate and the Chief Court Administrator, or their designees.

(c) Any member of the task force appointed under subdivision (1), (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member of the General Assembly.

(d) All appointments to the task force shall be made not later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(e) The speaker of the House of Representatives and the president pro tempore of the Senate shall select the chairpersons of the task force from among the members of the task force. Such chairpersons shall schedule the first meeting of the task force, which shall be held not later than sixty days after the effective date of this section.

(f) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall serve as administrative staff of the task force.

(g) Not later than January 1, 2014, the task force shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to insurance, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2014, whichever is later.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section

INS *Joint Favorable*

Appendix II

OptumInsight Actuarial Report

ACTUARIAL REPORT FOR THE STATE OF CT

ON 2014 HEALTH INSURANCE MANDATES

By

Steven J Stender, FSA, MAAA
Julia Xiao, CERA, ASA, MAAA

Table of content

I. Executive Summary

This report serves to record the findings of Optum pursuant to our engagement to provide actuarial services to the State of CT in conjunction with Public Act 09-179. It is intended to communicate the results of our work. This report supplements the three mandates reviewed in 2013 with one additional mandate.

Based on Optum's study of the proposed mandates, the coverage requirements will increase costs to certain fully insured plans that do not currently provide coverage for Court Mandated Services.

This mandates offers *coverage for and program enrollment options for treatment that is ordered by a court for mental disorders.* It is expected to add the premium of $0.440 PMPM (0.091%) in 2014. The five year projection for the cost of the mandate through additional premium is estimated at $35.2 million dollars.

Note: In the estimates above, a range of projected cost estimates has been used as well as a point estimate in some cases. The point estimate is not intended to imply a false sense of precision. Some aspects of the calculations may involve actuarial judgment. The actual 2014 cost could be greater or less than the expected values that have been projected.

The term de minimis is used to describe the projected incremental cost of any mandate that we expect to be less than $0.05 per member per month (PMPM) when the cost is spread to all the insured people covered by the plan. We also use the terms per person per month and per insured person per month to mean the same thing as PMPM. When considering the term PMPM, bear in mind that the average "person" is a blend of all ages and genders.

II. Introduction

A. Context of this report

This report serves to supplement the findings of Optum pursuant to our engagement to provide actuarial services to the State of CT in conjunction with Public Act 09-179 as to include one additional mandate. It is intended to communicate the results of our work.

Optum is pleased to have been chosen to serve the State of CT in this valuable project. A team approach has been employed, both internally at Optum and with the workgroup that includes the CT Insurance Department and the University of Connecticut Center for Public Health and Health Policy. Consulting health actuaries, Steven Stender, FSA, MAAA and Julia Xiao, CERA, ASA, MAAA of Optum in New York, NY managed the actuarial work for this project. Dr. Thomas Knabel, MD was responsible for clinical guidance and support.

Optum was retained by the state to assess several health insurance mandates for 2014. In this document, our findings and conclusions related to the actuarial evaluation are presented for the final mandate. It has been reviewed with respect

to cost and utilization, with additional commentary on their socio-economic impact and effect on the finance and delivery system where applicable. This is referred to as the Phase Five Actuarial Report.

The results are presented in several steps: First, in summary form, and subsequently, the additional data and calculations that support the findings are layered into the report.

B. Proposed mandate(s) under review

SB 1091: "Mental Disorder and Drug Addiction". Health insurance coverage for treatment that is ordered by the court for mental disorders. The proposed language would require health insurance "coverage for and program enrollment options for treatment that is ordered by a court for mental disorders".

Court ordered treatments for mental disorders may come from different court systems and may be acted through different treatments. The treatments are primarily ordered by the Superior Court through Court Support Services Division (CSSD), or from referral to the Department of Mental Health and Addiction Services (DMHAS) and by the Probate Court. Treatments may include involuntary commitment to an inpatient institution, participation in substance abuse programs, shock therapies and other treatments as mandated from the various court systems.

CSSD will typically order services for those who have entered the criminal court system. Therefore, the required programs and treatments are often in response to actions they have taken. The goal of CSSD is to change the individual's behavior in a positive way to enhance community and victim safety.

DMHAS promotes and administers comprehensive, recovery-oriented services in the areas of mental health treatment and substance abuse prevention and treatment. This includes inpatient hospitalization, outpatient clinical services, 24-hour emergency care, day treatment, psychosocial and vocational rehabilitation, restoration to competency and forensic services (including jail diversion programs), outreach services for persons with serious mental illness who are homeless, and comprehensive, community-based mental health treatment and support services.

Probate court assigns guardians or conservatorship for minors or adults to supervise the personal affairs of individuals unable to meet essential requirements of personal needs including healthcare and personal safety. Probate courts can also approve involuntary commitments to inpatient mental health and substance use disorder facilities.

The mandate only covers medically necessary services and treatment not specifically cited as an excluded benefit. The purpose is to allow claims where they would otherwise be denied since the original referral came due to a court ordered service. Health plans exclude treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, and paraphilias. This brings many of the services provided through CSSD out of scope of this mandate (e.g. Juvenile Sex Offender Services).

C. Objective

The objective of the report is to communicate our findings related to the actuarial evaluation of this proposed mandate with respect to cost and utilization along with comments on their economic impact.

D. Components of health insurance premium

With respect to the cost of health insurance mandates and their effect on commercial health insurance premiums, two separate pieces were examined—these are the two components of health insurance premiums:

1. Medical costs, also called benefit expense, and
2. Non-medical cost, also called non-benefit expense.

For a more comprehensive description of these costs, please review the December 31, 2013 report developed on the first three 2014 mandates.

The year one 2014 non-medical expense for this mandate is expected to be about $0.066 PMPM in addition to the $0.374 of paid medical cost for group plans. This is the total non-benefit expense and reflects more than operational costs only. As a range, this total non-medical cost is expected to be about $0.02 to $0.08 PMPM, depending on the level of medical cost and the operational changes that insurers and HMOs will need to make in order to comply with the mandates.

III. Health Insurance Context

Please review the previous reports for a comprehensive description of the health insurance context with regard to mandates and the associated premiums from where this mandate's impact on premium rates was assumed.

IV. Methods

A. Data/Survey

i. Optum Large Group Commercial database

Optum data was extracted for the purposes of this study. Optum's internal commercial health claims data for 2011 – 2012 was examined. The database captured approximately 7 million covered lives nationwide less than 65 years of old with 135,000 residing in CT. Various outside data sources were also reviewed in order to establish incidence and prevalence rates, utilization levels, unit cost of services, and overall spending on types of service. Optum used national and CT-specific health claims data.

ii. Carrier claims data

A survey was developed by the workgroup consisting of the University of Connecticut Center for Public Health and Health Policy and Optum. This survey was sent to each of the six health insurance carriers domiciled in CT. They were asked to provide responses reflective of the group health plans, individual policies, and Administrative Service Only (ASO) contracts. They were also asked to provide internal documents describing their medical management policies pertaining to the mandate.

At the time this actuarial report was completed, only five of the six carriers responded to the questions on this mandate. However, the quality and usefulness of the responses varied.

iii. External data sources

Average premium and cost sharing by policy type is based on AHRQ (2012) Medical Expenditure Panel Survey (MEPS) – insurance component. MEPS is a nationally representative survey of medical insurance, expenditure, utilization, and health status.

State-specific demographic information and income estimates come from the Census (2012) Current Population Survey.

Average premium by plan type for CT is based on 2012 CT Insurance Department filings.

B. Estimation/Projections

Optum's internal commercial health claims data for 2011-2012 was examined. The cost estimates were done on both a national level and a state level, with emphasis on the CT data. Where CT data was unavailable, national data was substituted with an area adjustment to reflect CT cost levels. The methodology Optum for the mandate is outlined below.

Methodology

- Obtain plan enrollment and characteristics including number of children and adults obtaining behavioral health services.
- Obtain plan enrollment information with prescription drug coverage.
- Compile medical and prescription drug claims with behavioral health services related diagnosis codes and procedural codes.
- Identify the treatment patterns for the services provided through court order. Where unavailable, substitute a proxy style treatment to estimate costs.
- The treatments studied include:
    - In patient behavioral health services.
    - In patient behavioral health services provided without included room and board services in the estimation.
    - Outpatient services.
    - In patient substance abuse services.
    - Outpatient substance abuse services.
    - Substance abuse group therapy.
    - Behavioral group therapy.
- Determine the cost of evaluation and treatment for 2011 and 2012.
    - Calculate total allowed cost, total paid cost, total cost share, and average cost of procedure for each treatment.
    - Calculate allowed cost, paid cost, cost share for the diagnosis and each treatment.
    - Calculate distribution of allowed cost, paid cost, and cost share.
- Determine the utilization rate of treatment for 2011 and 2012.
    - Obtain total utilization of mandated services by the various court agencies.
    - Estimate the distribution of treatments for each service provided.
    - Estimate the percentage of treatments where the patient has private commercial insurance (fully insured).
- Model the cost of the proposed mandate.
    - Calculate the number of people receiving each of these treatments where they have private insurance times the cost of the treatments.
    - Aggregate all the costs and divide by the number of fully insured individuals estimated within the State of CT.
    - Divide by 12 to determine a PMPM cost for this mandate.

C. Limitations

In estimating the 2014 medical cost of the mandates reviewed in this report, it was assumed that the mandates would become effective on January 1, 2014 and remain in effect throughout the entire calendar year. In the five year projection, future cost increases are explained.

In estimating the costs of these mandates, carriers do not capture within the claim information whether the mental health or behavioral treatment was ordered by the court. Therefore, we have used treatments most closely aligning to what is documented as being mandated by the courts.

Neither the court system nor their vendors record whether an individual with a court ordered treatment has private insurance. Additionally, even when they have private insurance, the private insurance is not always billed for the services being provided. Therefore the actual historical utilization of services for patients with private insurance is not evident. Additionally, even when assuming the percentage of patients who have private insurance, it is unknown the percentage of fully insured (where there is a potential impact of the mandate) versus self-funded (the mandate would not apply to self-funded plans).

Estimates were made assuming:

- Medically necessary criteria would still be applied by the insurance carriers in determining coverage. It is assumed they would still be able to apply their own determination even when it differs from the court appointed clinician.
- Services only towards treatment (or the evaluation for the purposes of treatment) would be covered by this mandate. Mental health and behavioral services not related to treatment such as determining competency to stand trial would not be included in this mandate
- Standard exclusions would still apply even when the court mandates these services. An example would include Juvenile Sex Offender Services as plans often exclude paraphilia.
- Costs were projected using standard commercial submitted and allowable charges. It is unclear whether the CSSD contracted rates or the commercial standard network rates would apply to these individuals.

If the mandate would require changes to any of the aforementioned assumptions, the cost of the mandate would change.

Since the mental health treatments are not known, Optum data was used as a basis for assuming utilization of mental health and substance abuse services. Adjustments were made to assume more intensive services due to a population referred from a court. If the actual services are different from those assumed, any projections will be impacted.

Throughout the calculations, due to limited available data, various assumptions were made. Where possible, points of reference for similar methodologies were

considered in developing these assumptions. Actual experience may differ from these assumptions impacting the results of the study.

V. Actuarial Report

A. 2014 Projections:

We have used the term PMPM (per member per month) and per insured person per month to mean the same thing in the following projections. The latter term is meant to convey that the cost of the mandated benefit has been spread to the entire insured population.

In examining the cost of the mandates, we looked at the frequency (or utilization) of the mandated services separate from the unit cost per service. The PMPM cost is the product of the monthly frequency per member times the unit cost. Utilization may be expressed as per person or per thousand people basis. Utilization is usually expressed on an annual basis but may also be on a per month basis. Appropriate conversion was used to obtain a PMPM cost.

The mandate covers both coverage and program enrollment options for treatment by a court for mental disorders. In order to estimate the claims costs, it is first necessary to identify the treatments and program options offered by the agencies.

The programs and treatments serviced through the courts and its agencies are as follows:

Court Support Services Division:

Adult:

- Adult Behavioral Health Services (ABHS) -- Integrated substance abuse and mental health evaluations, substance abuse, mental health, anger management and relapse preventions groups, intensive outpatient treatment, individual treatment, substance abuse testing, medication evaluations and medication management

Juvenile:

- Multisystemic Therapy (MST) -- An intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behaviors including substance abuse in juvenile offenders.
- Multidimensional Family Therapy (MDFT) -- A family-based, comprehensive treatment system for adolescent drug abuse and related behavioral and emotional problems.
- Multidimensional Family Therapy Community Residential Program (MDFT CRP) -- A staff secure 4 month therapeutic residential program that incorporates Multidimensional Family Therapy. Serves 11-17 year age on juvenile probation and on a case by case basis 17 years of age on adult

probation or involved with Bail. All clients must be returning home after their stay at this program and in home services start within two weeks of the intake. In home services are provided throughout the client's residential stay and up to 6 months after discharge. Referrals can have substance abuse histories and often have a mental health diagnosis. On site education, medical mental health and recreational services are provided. Off campus activities are provided under staff supervision.

- Court-Based Assessments (CBA) Evaluation by contracted licensed mental health evaluators (Psychiatrists, Psychologists, Clinical Social Workers) as ordered by Superior Court for Juvenile Matters. Evaluations include Psychiatric, Psychological, Substance Abuse and Psycho-sexual.

Department of Mental Health and Addiction Services:

- Substance Dependence – Evaluation
- Substance Dependence – Treatment (inpatient)
- Probation requirement for treatment

Probate Court:

- Electroconvulsive therapy (ECT) -- permission to provide treatment
- Involuntary Commitment
- Forced Medication

As a proxy for determining cost of the services, we priced the costs for members who obtain the following services:

Adult:

- Inpatient mental and behavioral health services with length of stay >5 days (intensive)
- Inpatient mental and behavioral health services with length of stay >5 days (intensive) with room and board costs excluded
- Inpatient mental and behavioral health services with length of stay <=5 days (less intensive)
- Inpatient mental and behavioral health services with length of stay <=5 days (less intensive) with room and board costs excluded
- Inpatient substance abuse services with length of stay >5 days (intensive)
- Inpatient substance abuse services with length of stay >5 days (intensive) with room and board costs excluded
- Inpatient substance abuse services with length of stay <=5 days (less intensive)
- Inpatient substance abuse services with length of stay <=5 days (less intensive) with room and board costs excluded
- Outpatient mental and behavioral health services (intensive)
- Outpatient mental and behavioral health services (less intensive)
- Outpatient substance abuse services (intensive)
- Outpatient substance abuse services (less intensive)

- Diagnostics and testing for mental health conditions
- Behavioral/emotional group therapies
- Substance abuse group therapies
- Electroconvulsive therapy (per admit)
- Schizophrenia (per admit)

Juvenile:

- Inpatient mental and behavioral health services with length of stay >5 days (intensive)
- Inpatient mental and behavioral health services with length of stay >5 days (intensive) with room and board costs excluded
- Inpatient mental and behavioral health services with length of stay <=5 days (less intensive)
- Inpatient mental and behavioral health services with length of stay <=5 days (less intensive) with room and board costs excluded
- Inpatient substance abuse services with length of stay >5 days (intensive)
- Inpatient substance abuse services with length of stay >5 days (intensive) with room and board costs excluded
- Inpatient substance abuse services with length of stay <=5 days (less intensive)
- Inpatient substance abuse services with length of stay <=5 days (less intensive) with room and board costs excluded
- Outpatient mental and behavioral health services (intensive)
- Outpatient mental and behavioral health services (less intensive)
- Outpatient substance abuse services (intensive)
- Outpatient substance abuse services (less intensive)
- Diagnostics and testing for mental health conditions

Based on data submitted from the various agencies providing services, we estimated 13,901 adults receiving various treatments through the ABHS, 800 juveniles receiving various treatments and 1,465 individuals being clinically assessed by the court system. We also estimated 1,390 individual involuntarily committed through probate court and 122 receiving permission for shock treatment.

For referrals made through the Superior Court (CSSD and DMHAS), information on the treatments performed for each of these individuals were unavailable. Instead, we used the distribution of services within the Optum database as a proxy for typical services provided and then adjusted the claims to reflect an expectation of more intensive services provided as these individuals are being referred by the court system. For individuals referred through the probate court, exact figures were provided although the method of treatments made were not available. For these individuals, (with the exception of electroconvulsive therapy), in-patient claims for individuals with schizophrenia was used as a proxy for the expected costs.

Claims costs were projected using the Optum database. All claims were adjusted to reflect the typical costs for the population within the State of Connecticut and trended to mid-year 2014. To project claim costs, we reviewed behavioral health

claims from over 440,000 individuals nationally within the Optum database between 2011 and 2012.

Finally, we assumed 10% of the population within the courts has private insurance available of which 39.5% were fully insured. The 10% assumption is based on discussions between the University of Connecticut Center for Public Health and Health Policy and the various state agencies as well as a survey of providers contracted with CSSD. The 39.5% assumption is based on section 3 of the December 2013 report

Based on these assumptions and estimates provided, we project 583 (551 adults and 32 children) covered fully-insured individuals to be treated through the Superior Court orders. Additionally, we project 58 fully insured individuals to be clinically assessed through the courts. Finally, we estimate 60 fully insured individuals to be committed through the probate courts.

Court	Column1	Utilization	Costs	Total Paid
Superior Court	Treatments	583	8,187.57	4,773,501.59
Superior Court	Assessments	58	140.96	8157.00
Probate Court		60	10,706.33	639,424.56
Total		701	7,737.66	5,421,083.15

Based on the population of fully insured individuals within the State of Connecticut, we expect the cost for clinical assessment and treatments within the scope of covered benefits for fully insured individuals to be approximately $0.3739 PMPM (Superior Court -- $0.3298 and Probate Court $0.0441).

Assuming the average medical cost ratio for group would be 85%, estimated premium for this mandate is shown below including low, middle, high end PMPM based on the paid medical cost distribution.

Estimated premium PMPM		
Low	(25th percentile)	$0.1135
Middle	(mean)	$0.4399
High	(75th percentile)	$0.5214

Carrier data:

Of six carriers requested in the survey, five carriers responded to questions regarding their existing benefit coverage as compared to the proposed mandate. All mentioned they do not deny coverage due to court mandated services. Two carriers mentioned they apply medically necessity when assessing to pay for any benefits and it may differ from the courts. In discussion with one carrier, they mentioned many services would be excluded from coverage and medical necessity may differ from those directed by the clinician for the court.

Financial and Economic Analysis of Phase Five 2014 Mandates

Introduction:

In prior phases reviewing the State of Connecticut's mandated benefits, this section containing the financial and economic analysis began with a summary of the state of health coverage in the state of CT. Most of that same summary is incorporated here with minor revisions and some updating consistent with the 2013 mandates. The original write-up was completed in early 2011 by Tanvir Khan and Krista King with assistance from Dr. Tom Knabel and Dan Bailey:

The availability of healthcare coverage and its impact on families by income are discussed in the report developed December 31, 2013 on the first three mandates. Cost-burden to the individual and family is discussed. A broader interpretation of financial burden was discussed in the same report. Since the court pays all cost sharing for services ordered by the Superior Court, this report does not review any financial burden for the services ordered by the court. Conversely, cost sharing for services ordered by the Probate Court may be borne by the individual and are therefore reviewed below.

Lost productivity was not reviewed for this mandate. For those receiving services ordered through the Superior Court, there are other mitigating circumstances causing their lost productivity. For those receiving services ordered by the Probate Court, it is unlikely the availability of treatment and limited individuals where these services would apply would have any significant impact on their productivity.

Economic status of CT population

A. Demographics -- Income
To understand health coverage in CT, first the entire CT population is examined; then, two smaller subsets:

Prior to any mandate, the entire burden of the disease is borne by the member (lacking any external form of financial assistance). Therefore, to understand the impact of the illness on the population, it is important to demonstrate the current financial landscape of Connecticut residents.

According to the US Census bureau, the mean income of CT households is $95,032 with a median income of $67,544. The 25th Percentile is approximately $34,000 and the 75th percentile is $120,000.

B. Demographics – Population

As mentioned in the December 2013 report, for those with health coverage, all people of all ages are considered—this includes everyone residing in CT. According to the census annual estimate for 2012, that is 3,590,347 people of which 3,058,976 are under 65 years of age. It includes people who have any type of health coverage whether fully insured or not, whether private or public. It also

includes people who have no health coverage—the uninsured. For the purposes of calculating the costs of this mandate, we have assumed 69% of individuals under 65 year of age have employer coverage of which 60.5% self-funded and 39.5% fully insured. That is, the 69% employer-based coverage breaks down further into 42% self-funded group and 27% fully insured group. Although the State plans currently have chosen to comply with all insurance benefit mandates, they are not required to do so and therefore they are included in the self-funded 65%. The state EEs and their dependents are approximately 5% of the CT population and are the largest commercial group in the state.

According to the Connecticut Insurance Department, it is expected due to ACA, there will approximately 200,000 additional individuals obtaining insurance either through the individual coverage or through employer-based coverage. Of those, we expect 90% to be fully insured and potentially impacted by these mandates. Additionally, from the employer-covered population we expect there to be an additional shift of employers moving towards self-funding up to 65% of the employer sponsored coverage population and removing the covered individuals from these mandates. The resulting assumption is approximately 1.1 million individuals to be covered by insurance plans impacted by these mandates. The state of CT has historically included the mandates in the coverage of their employees. If this continues, there would be just over 1.3 million individuals covered by these mandates. The chart below shows the expected distribution in 2014:

ALL CT RESIDENTS, Projected 2014, <65 years

TYPE OF HEALTH COVERAGE	
Group Fully Insured	**24.2%**
Individual Fully Insured	**7.5%**
Self-Funded Group	**44.9%**
Medicaid	**12.9%**
Medicare	**0.8%**
Military	**9.2%**
Uninsured	**1.2%**
Other Public	**0%**

C. Cost of Health Care Medical Insurance

As mentioned earlier in the December 2013 report (section III (D)), the cost of insurance is very different between those with employer coverage and those purchasing directly for individual coverage. The total premiums and insured's portion of the average premium are reflected in the chart below:

Large Group		Small Group		Individual	
Covered Lives	**Avg. Premium**	**Covered Lives**	**Avg. Premium**	**Covered Lives**	**Avg. Premium**
332,159	$5,011.11	304,258	$6,582.26	110,355	$3,640.61

Data source: CPHHP 2013 CT Carrier survey 2012 data average costs per member projected to 2014

Even with these typical policies and average premium mentioned above, the healthcare landscape has changed significantly reflecting two very different types of coverage with very different costs. High deductible health plans are increasingly common, especially in the individual and small group markets. America's Health Insurance Plans (AHIP) estimates that nationally over ten million lives were covered in 2010 under Health Savings Account/High-Deductible Health Plans (HSA/HDHP).

In Connecticut, almost 10% of the lives covered by commercial health insurance have an HSA/HDHP plan. Per IRS rules, these plans have an inflation indexed minimum deductible for individual and family coverage (for 2013, the minimum family deductible is $2,500). Without some modification of benefit design, the high deductible in such plans can be a deterrent to services that are of high value and much needed. For example, if one had to wait until a $2,500 deductible is satisfied in order to get a medically necessary service, the tendency might be to wait rather than pay. As a result of the Affordable Care Act (ACA), however, crucial preventive services are now provided by health insurance plans with no member cost-sharing.

Financial Burden

Upon reviewing each mandate, there is a potential burden impacting a member

1. Without health care coverage.
2. With health care coverage that is not subject to the mandate.
3. With fully-insured health care coverage that is subject to the mandate.

When the member has no insurance coverage, he or she will be responsible for the submitted charge or some discount thereof. This may be higher than the allowed costs used by insurers in calculating their initial liability. Hence, the full burden of the costs falls upon the patient. Please review the December 2013 report on the first three mandates for a more comprehensive review of the financial burden impacting the individual member.

As mentioned earlier, for this mandate, only those costs for treatments ordered by the Probate Courts may be borne by the member and are reviewed in this report. All cost sharing from services ordered by the Superior Court are paid by the court. Therefore no cost sharing projections are for the treatments ordered by the Superior Court are shared and included in the economic report.

Even prior to the passage of the ACA, insurers recognized the member's propensity to delay care and countered with new and improved plan designs designed to encourage access to benefits that bring higher value for cost. When there is cost sharing to be borne by the member, a member may defer or delay treatment due to its financial impact. However, since these services are being ordered through the court system, the member is not being offered the option to delay care. Therefore, plan design should not materially impact the expected access or utilization of treatments being provided

Financial Burden Review of Individual Mandates

Cost Burden of Court Ordered Services

For the Court Ordered Services mandate, we are referring to essentially two categories of care. Involuntary commitment which can be due to a mental/behavioral health condition or the need for forced medication, and permission for receiving electro-convulsive therapy (shock treatments). For involuntary commitments, we modeled a patient using schizophrenia as a proxy to estimate the costs. For patients with schizophrenia and those receiving shock treatment, we estimate the cost per admit.

Based on the review of national data, only 0.0004% of members or 61 members are expected to be receiving treatments ordered by the probate court while being fully insured and impacted by this mandate.

For members with behavioral health services, the following is the expected cost share distribution amongst members.

2012 Behavioral Health Cost Share Distributions for Members with Mental and Behavioral Health Claims

Cost Share amount	National Member Count	National Distribution
$0.00	8,325	11.536%
$0.01 to $20.00	9,772	13.542%
$20.01 to $50.00	10,200	14.135%
$50.01 to $100.00	9,981	13.831%
$100.01 to $200.00	9,922	13.749%
$200.01 to $300.00	5,287	7.326%
$300.01 to $500.00	5,328	7.383%
$500.01 to $750.00	3,628	5.028%
$750.01 to $1000.00	2,257	3.128%

The cost for the diagnosis and treatments ordered by the Probate Court are as follows

	Allowed	Paid	Average cost sharing		Individual Silver	High Deductible
	(Uninsured)		10% Cost Share	20% Cost Share	30% cost sharing	Assumed $2500/20%
Schizophrenia	$10,826	$10,153	$673	$673	$1,346	$3,331
Shock Therapy	$17,594	$17,010	$584	$584	$1,168	$5,024

Note: These individuals typically have other health issues using up a considerable portion of the deductible and out of pocket maximum limits. Therefore, for high deductible plans, we assumed $2,500 deductible of which half would already be exhausted and an average cost sharing of 25% above the deductible. For individual (silver) plans, we capped the out of pocket limit at the minimum of the appropriate coinsurance or two times the difference between the average allowed and paid costs. For all plans, cost sharing was capped at the ACA mandated $6,350 out of pocket limit.

For various income levels, the following is the expected financial burden as a percentage of income for the uninsured and for those with varying levels of coverage if the mandate is approved.

	Allowed	Paid	Average cost sharing		Individual Silver	Average cost sharing
	(Uninsured)		10% Cost Share	20% Cost Share	30% cost sharing	High Deductible
Income level	$35,000	$35,000	$35,000	$35,000	$35,000	$35,000
Schizophrenia	10,826	10,153	673	673	1,346	3,331
% of income	30.9%	29.0%	1.9%	1.9%	3.8%	9.5%
Shock Therapy	17,594	17,010	584	584	1,168	5,024
% of income	50.3%	48.6%	1.7%	1.7%	3.3%	14.4%
Income level	$65,000	$65,000	$65,000	$65,000	$65,000	$65,000
Schizophrenia	10,826	10,153	673	673	1,346	3,331
% of income	16.7%	15.6%	1.0%	1.0%	2.1%	5.1%
Shock Therapy	17,594	17,010	584	584	1,168	5,024
% of income	27.1%	26.2%	0.9%	0.9%	1.8%	7.7%
Income level	$95,000	$95,000	$95,000	$95,000	$95,000	$95,000
Schizophrenia	10,826	10,153	673	673	1,346	3,331
% of income	11.4%	10.7%	0.7%	0.7%	1.4%	3.5%
Shock Therapy	17,594	17,010	584	584	1,168	5,024
% of income	18.5%	17.9%	0.6%	0.6%	1.2%	5.3%
Income level	$120,000	$120,000	$120,000	$120,000	$120,000	$120,000
Schizophrenia	10,826	10,153	673	673	1,346	3,331
% of income	9.0%	8.5%	0.6%	0.6%	1.1%	2.8%
Shock Therapy	17,594	17,010	584	584	1,168	5,024
% of income	14.7%	14.2%	0.5%	0.5%	1.0%	4.2%

Five Year Projections

Five Year Projections for Court Ordered Services Mandate

A. Change in Utilization

For 2014, we assumed private fully insured insurance would be responsible for 701 people through the court system. As the court is ordering this coverage due to the nature of the behavioral condition as well as the actions of the member, there are no expected changes to utilization due to these services being covered by insurance. If the court expands the scope of services provided or if treatment protocols change, there may be a difference in costs than those estimated

B. Change in Unit Cost

The treatment protocols ordered for the purposes of this mandate may lead to higher reimbursement to the providers if they are paid on a commercial schedule instead of the schedule contracted by CSSD and DMHAS with their providers. For probate court, no change in cost is expected as these providers are not directly contracted with the courts.

C. PMPM Costs

In calculating the PMPM costs over five years, we assumed similar utilization of services for each year based on the services provided. Therefore five year costs are a multiple of the first year costs with an adjustment for trend.

For this mandate, the projected five year premium cost is expected to be $0.4861 PMPM or $35,241,066 over five years

[END OF FINANCIAL AND ECONOMIC SECTION]

LIMITATIONS IN USE:

This study was conducted by Optum exclusively for the State of CT and specifically and solely as it applies to the evaluation of the benefit mandates discussed in this report. This statement of opinion is not intended for any other application or purpose. I, Steven J. Stender, am a consulting health actuary and Director with Optum. I am a fellow of the Society of Actuaries and a member of the American Academy of Actuaries, in good standing, and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. Please contact me if you have questions. My e-mail address is steven.stender@optum.com, and my office phone is 212-817-6018.

Steven J Stender, FSA, MAAA

Appendices

PMPM COST INDIVIDUAL COVERAGE PLANS PROJECTED 2014 COSTS (PMPM)	
Individual premium developed as weighted average from carrier surveys	
Average Individual Premium:	$303.38

NOTE: Individual data is less credible than group data due to small sample size

PROJECTED 2014 PMPM COST FOR INDIVIDUAL COVERAGE PLANS						
			=A - B		= C + D	
	A	B	C	D	E	F
Mandate	**Allowed Cost**	**Cost Share**	**Paid Cost**	**Retention**	**Paid Cost + Retention**	**% of Premium**
Superior Court	0.3801	NA	0.2661	0.0389	0.3050	0.10%
Probate Court	0.0508	NA	0.0356	0.0052	0.0408	0.01%
Total	0.4310	0.1293	0.3017	0.0441	0.3458	0.11%

PMPM COST GROUP COVERAGE	
PROJECTED 2014 COSTS (PMPM)	
Group premium developed as weighted average from carrier surveys	
Average Group Premium	
Any Size	$482.42
<100 Employees	$548.52
100+ Employees	$417.59

PROJECTED 2014 PMPM COST FOR GROUP COVERAGE PLANS								
			=A - B		= C + D			
	A	**B**	**C**	**D**	**E**	**F**	**G**	**H**
							% of Premium	
Mandate	**Allowed Cost**	**Cost Share**	**Paid Cost**	**Retention**	**Paid Cost + Retention**	**% of Premium**	**Group Size < 100 Ees**	**Group Size 100+ Ees**
Superior Court	0.3801	NA	0.3298	0.0582	0.3880	0.08%	0.07%	0.09%
Probate Court	0.0508	NA	0.0441	0.0078	0.0519	0.01%	0.01%	0.01%
Total	0.4310	0.0571	0.3739	0.0660	0.4399	0.09%	0.08%	0.11%

TOTAL DOLLAR COST CALCULATION	
PROJECTED 2014 COSTS (dollars)	
TOTAL COST CALCULATION BASED ON:	
Total Insured's (Group + Individual)	1,146,887
Group (Excluding State)	828,936
Group (State Only)	161,368

PROJECTED 2014 MONTHLY COST FOR GROUP COVERAGE PLANS						
	A	**B**	**C**	**D**	**E**	**F**
	Allowed Cost		Paid Cost + Retention	Allowed Cost + Retention	Paid Cost	Paid Cost
MANDATE	**Total Cost of Health Care**	**Paid Cost**	**Premium Impact**	**Overall Cost to Health Care System**	**Total Paid Cost for the State Employee Health Plan**	**Total Paid Cost for Fully Insured + State Employees**
GROUP + INDIVIDUAL						
Superior Court	$435,959	$357,969	$421,140	$375,720		
Probate Court	$58,298	$47,869	$56,317	$50,243		
Total	$494,257	$405,838	$477,457	$425,963		
GROUP ONLY						
Superior Court	$315,098	$273,366	$321,608	$363,339	$53,216	$326,582
Probate Court	$42,136	$36,556	$43,007	$48,587	$7,116	$43,672
Total	$357,234	$309,922	$364,614	$411,927	$60,332	$370,254

COST OF MANDATED HEALTH CARE BENEFIT ON COST OF HEALTH CARE BY EMPLOYER SIZE

PMPM COST SMALL GROUP (< 100 EMPLOYEES) COVERAGE						
			= A - B		=C + D	
	A	B	C	D	E	G
Mandate	Allowed Cost	Cost Share	Paid Cost	Retention	Paid Cost + Retention	% of Premium
Superior Court	0.3801	NA	0.3298	0.0609	0.3907	0.07%
Probate Court	0.0508	NA	0.0441	0.0081	0.0522	0.01%
Total	0.4310	0.0571	0.3739	0.0691	0.4429	0.08%

PMPM COST LARGE GROUP(100+ EMPLOYEES) COVERAGE						
			= A - B		=C + D	
	A	B	C	D	E	G
Mandate	Allowed Cost	Cost Share	Paid Cost	Retention	Paid Cost + Retention	% of Premium
Superior Court	0.3801	NA	0.3298	0.0561	0.3859	0.09%
Probate Court	0.0508	NA	0.0441	0.0075	0.0516	0.01%
Total	0.4310	0.0571	0.3739	0.0636	0.4375	0.10%

Appendix III

CSSD Contracted Providers Survey

CSSD Contracted Providers Survey

Introduction

Dear CSSD service provider, CSSD is partnering with the UConn Center for Public Health and Health Policy (CPHHP) to collect information from CSSD contracted services providers. CPHHP has been contracted by the Committee on Insurance and Real Estate of the CT General Assembly to review a proposed mandate that would require private insurance carriers to cover services for mental and substance use disorders ordered by the judiciary. Answers to this survey will provide information CPHHP requires to complete their review. Please complete this survey at your earliest opportunity. When completing the survey, please keep in mind that we are assessing care of a medical/psychiatric nature and, as such, please exclude other types of services that a private insurance carrier would be unlikely to cover, such as education or transportation. It may be beneficial to print the survey and distribute it to the appropriate people in your organization to calculate the numbers we are requesting before completing the survey online. If you are unable to calculate your responses, please coordinate with the most informed colleagues at your organization for estimations. **Please complete the online survey before 5PM on Friday, November 29, 2013**, at which time the online survey will close. All results will be reported in aggregate form. No individuals or organizations will be identified in any reports or publications resulting from these data. Your responses will go directly to CPHHP and will not be reviewed by CSSD. Thank you in advance for your time and attention to this important effort. Please direct any comments or questions to the Study Coordinator: Andrew M. Cislo, PhD at cislo@uchc.edu (preferred) or 860-282-8575.

1. What was the total number of CSSD clients that your organization served in fiscal year 2012?

Number of CSSD clients served in FY 2012:

2. What proportion (%) of your fiscal year 2012 CSSD clients were juveniles? (i.e. under 18 years of age)

3. What proportion of your CSSD clients were treated for substance use disorder in fiscal year 2012?

4. What proportion of your CSSD clients were treated for a mental disorder (excluding substance use) in fiscal year 2012?

5. Among the adult CSSD clients that you served in fiscal year 2012, what was the proportion who had private insurance coverage?

6. Among the juvenile CSSD clients that you served in fiscal year 2012, what was the proportion who had private insurance coverage?

7. What was the aggregate dollar cost of services provided to CSSD clients in fiscal year 2012 for care that a private insurance carrier might cover?

Total cost of applicable services to CSSD clients in FY 2012:

CSSD Contracted Providers Survey

8. What was the aggregate dollar cost of services provided to CSSD clients in FY 2012 who had private insurance?

Total cost for CSSD clients with private insurance in FY 2012:

9. What was the total number of dollars billed to the private insurance carriers for CSSD clients in fiscal year 2012?

Total dollars billed to CSSD clients' private insurance in FY 2012:

10. What was the total dollar amount collected from private insurance carriers for CSSD clients in fiscal year 2012?

Total dollars received from CSSD clients' private insurance in FYI 2012:

11. What was the total dollar amount denied by private insurance carriers for CSSD clients in fiscal year 2012?

Total dollars denied by private insurance for CSSD clients in FY 2012:

12. What was the total dollar amount that was cost shared by CSSD clients in fiscal year 2012?

Total dollars paid by CSSD clients in FY 2012:

13. What was the total dollar amount that was cost shared by Court Support Services Division in fiscal year 2012?

Total dollars covered by CSSD in FY 2012:

14. What was the total dollar amount for services to CSSD clients that was covered by public insurance (e.g. Medicaid) in fiscal year 2012?

Total dollars covered by public insurance in FY 2012:

15. For CSSD clients with private insurance whose claims were denied in fiscal year 2012, what proportion of patients were denied because services were court-ordered?

16. For CSSD clients with private insurance whose claims were denied in fiscal year 2012, what proportion of patients were denied because services were not judged medically necessary?

17. For CSSD clients with private insurance whose claims were denied in fiscal year 2012, what proportion of patients were denied because services were not covered under the insurance plan?

18. Please indicate whether your responses to the questions about were calculated or estimated or some combination:

- My responses were calculated
- My responses were estimated
- I both calculated and estimated my responses

19. Please feel free to comment on the capabilities and limitations of your data system in answering the above questions:

CSSD Contracted Providers Survey

20. Please feel free to add any additional comments:

Thank you for your time and participation!

Appendix IV

DHMAS Reponse to Legislative Request - Court Ordered Services

DMHAS Response to Legislative Request – Court Ordered Services 1-16-14

This report is in response to a request from Andrew M. Cislo, Ph.D., Assistant Professor, Department of Medicine & Center for Public Health and Health Policy, Director of Research and Evaluation, Correctional Managed Health Care, University of Connecticut Health Center. Dr. Cislo is preparing information for the CT Department of Insurance in response to a request from the Insurance and Real Estate Committee of the General Assembly regarding a proposed mandate for private insurance to cover the cost of court-ordered clinical services.

Specifically, Dr. Cislo has requested information regarding "1) substance dependence treatment (inpatient) and 2) probation requirement for treatment" in SFY 2012 and in SFY13.

1) Inpatient Substance Abuse Dependence Treatment

Two populations of court ordered adults are referred to the Division of Addiction Services at DMHAS' Connecticut Valley Hospital for residential substance abuse services. These referral sources are 1) the DMHAS Office of Forensic Evaluations (OFE) and 2) the Judicial Branch's Court Support Services Division (CSSD). Data regarding services for OFE clients is presented below. Data regarding services for CSSD clients (court-ordered pretrial defendants and probationers) is not immediately available but can be made available at a later time.

Residential substance abuse treatment subsequent to OFE Substance Dependence Evaluation
Services Provided by: DMHAS - Addiction Services Division (ASD) of Connecticut Valley Hospital (CVH)

The DMHAS Office of Forensic Evaluations (OFE) conducts Substance Dependence evaluations that are ordered by court per CGS 17a-694. OFE then sends a report to the court for consideration of substance abuse treatment in lieu of incarcerations. Some of these defendants are ordered to attend residential substance abuse treatment services and a subset of those defendants attend residential substance abuse treatment with the Addiction Services Division (ASD). Data below is for the latter defendants.

DMHAS Costs

	SFY 2012	SFY 2013
# Admissions from OFE Evaluations	59	42
All ASD admissions with private insurance	0.3%	0.3%
ALOS (days) for all ASD discharges	28.89	29.42
$/day cost ASD	$1,287	$1,427
Total cost/SFY = # OFE Admissions X ALOS X $/day	$2,193,704	$1,763,258

ALOS = average length of stay

- 0.3% of all admissions for ASD Residential Treatment had private insurance in each fiscal year. While it is unclear whether these were OFE admissions, the division Utilization Review Nurse indicated that private insurance has not approved payment for OFE admissions.
- Medicaid is not billed for these clients.
- It was verified with treatment teams that ALOS for OFE admissions has not been noted to be dramatically different than other admissions.

2) Probation Requirement for Treatment

DMHAS provides a wide range of services and does not have the ability to determine which clients are provided services in response to a requirement from the Judicial Branch's Office of Adult Probation.

Appendix V.

Glossary of Terms and Acroynyms

Glossary of Terms and Acronyms[1]

Term	Definition
ACA	Patient Protection and Affordable Care Act
CID	Connecticut Insurance Department.
CSSD	Court Support Services Division of the Connecticut Judicial Branch
Comorbidity	The co-occurring presence of two or more medical conditions.
Co-payment	The amount that a member must pay out-of-pocket for medical services. It is usually a fixed amount, such as $5, $10, or $25 per service.
CPHHP	Center for Public Health and Health Policy (University of Connecticut)
Deductible	That portion of a subscriber's (or member's) health care expenses that must be paid out-of-pocket before the insurance coverage applies (amounts vary depending on type of plan). Deductibles are common in insurance plans and PPOs, uncommon in HMOs. They may apply only to the out-of-network portion of a point-of-service plan or only to one portion of the plan coverage (e.g., just to pharmacy services).
DCF	Connecticut Department of Children and Families.
Delinquency	An offence or misdeed, usually of a minor nature, especially one committed by a young person.
DMHAS	Connecticut Department of Mental Health and Addiction Services
Electroconvulsive therapy/ECT	A treatment for serious mental illnesses, such as severe depressive disorders, involving the application of an electrical current to the head in order to induce a seizure: usually administered after sedatives and muscle relaxants.
Forensic	Pertaining to, connected with, or used in courts of law or public discussion and debate.
Group Coverage	A type of health insurance in which members receive coverage through an insurance contract that covers an entire group, usually an employment-based group. Employees usually have the option of covering other members of their families as well.
Health Maintenance Organization (HMO)	A type of managed care plan that acts as both insurer and provider of a comprehensive set of health care services to an enrolled population. Services are furnished through a network of providers.

1 Except where otherwise noted, definitions are taken from Dictionary.com, http://dictionary.reference.com/browse/mode?s=t

Term	Definition
Mandated benefits	Health benefits that a health coverage provider is required by law to provide. The federal government and many states mandate the coverage of specified benefits by certain health coverage providers. An example would include a defined number of days inpatient treatment for mental health or substance abuse, and other special-condition treatments.
Mental disorder	From C.G.S.A. §§38a-488a and 381-514: as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". "Mental or nervous conditions" does not include (1) mental retardation, (2) learning disorders, (3) motor skills disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".
Member	An individual covered under a managed care plan. Members include subscribers and dependents.
OHA	Connecticut Office of Health Care Access
Probation	A system of dealing with offenders by placing them under the supervision of a probation officer.
Per member per month (PMPM)	Cost for each enrolled member each month.
Premium Rate	The amount of money that a group or an individual must pay to a health plan for coverage. The payment is usually in the form of a monthly fee.
Subscriber	The individual or member who has the health plan coverage in virtue of being eligible on his or her own behalf rather than as a dependent.
Termination date	The day that health plan coverage ceases to be in effect.

Appendix VI.

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- Chris Pleasanton — The Community Court in Hartford

Insurers and managed care organizations in Connecticut responding to the survey.

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