Ensuring Access & Coverage in CT
For Substance Abuse Treatment

Report of the Connecticut Insurance Department

To

Governor Dannel P. Malloy
Insurance & Real Estate Committee
Public Health Committee

January 31, 2017
Connecticut’s approach to the opioid epidemic is comprehensive, proactive and leverages the expertise of partners from all sectors – government, business, not-for-profits, consumers and families, providers and insurers.

The Connecticut Insurance Department (CID) has been an active partner in working toward solutions across state government and employs a multi-faceted approach. Coverage for substance abuse disorder is a mandated benefit in the state for fully insured plans. The CID’s regulatory scrutiny ensures that fully insured health plans are in compliance with state and federal laws before they can be marketed in Connecticut. Our Consumer Affairs division investigates and adjudicates policyholder complaints and our Market Conduct division reviews company practices to make certain that consumers receive the benefits to which they are entitled.

Through advocacy and outreach, the CID helps educate consumers on using insurance. With our sister agencies, the CID visits communities to promote state resources for citizens struggling with addiction in their families.

The CID works hard to maintain a regulatory environment that protects consumers while promoting industry innovation. A CID-sponsored forum in October 2016 brought insurance companies into the public conversation to explain their programs and strategies in seeking the best practices for combatting opioid abuse, utilizing data, analytics and outcomes.

In accordance with special Act 16-4, we present the findings of a CID survey of 16 health insurance companies in Connecticut that examined coverage for mental health and substance abuse treatment, utilization review requirements, and cost sharing requirements.

We hope the Administration and the General Assembly find this report useful.

Respectfully submitted,

Katharine L. Wade

Katharine L. Wade
Insurance Commissioner
Access to Insurance Coverage Survey

The CID surveyed 16 health insurance companies to determine whether any barriers for substance abuse treatment existed for policyholders of the fully insured individual, small group and large group plans regulated by the CID. Specifically the CID study examined the:

- Extent to which coverage is provided under health insurance policies
- Types of treatments covered under such policies
- Requirements, if any, that policyholders must meet for such treatments to be covered
- Cost-sharing requirements for such treatments

Coverage Provided Under State Law

Connecticut General Statutes, Sections §38a-488a and §38a-514 mandate that all individual and group basic hospital, basic medical-surgical, major medical and health care center (HMO) policies provide benefits for the diagnosis and treatment of mental and nervous conditions and substance abuse disorders. These benefits must have parity with benefits for medical, surgical or other physical health conditions.

Payable Services

Under state law, if benefits are payable for services rendered by a licensed physician, then benefits are also payable for such services from licensed or certified psychologists, clinical or independent social workers, marital and family therapists, alcohol and drug counselors and professional counselors. This includes treatment in a residential facility or child guidance clinic
I. Ensuring Compliance

CID examiners review the policies before they are marketed to confirm compliance with state and federal laws, including mental health parity. Policies are reviewed for quantitative and non-quantitative measures of:

- Benefits
- Limitations
- Prior Authorization requirements
- Cost Sharing

Carriers also must provide annually to the CID a sworn actuarial demonstration that a plan’s cost-sharing meets federal mental health parity requirements.

Additionally, carriers must complete an annual mental health parity compliance survey, which is reviewed by CID to determine compliance with several benefit classifications:

- Inpatient in- and out-of-network
- Outpatient in- and out-of-network
- Emergency
- Prescription drugs

The CID review makes certain that the “substantially all” test is met by the plans. Information specific to non-quantitative treatment limitations – medical management, prior authorization and step therapy – is thoroughly reviewed.

The CID continues to monitor compliance through consumer complaints after the policies are sold. The CID’s Consumer Affairs Division investigates on behalf of the consumer to resolve the issue.

If a pattern of noncompliance is detected through multiple complaints, the matter is referred to the CID’s Market Conduct Division for further investigation. In addition, the Market Conduct Division regularly reviews the companies’ practices to ensure compliance with Connecticut standards.
From 2015 to the present, substance abuse claims issues identified and corrected through Market Conduct reviews and intervention were:

- Claims denials for improper provider coding for substance abuse treatment in an office setting
- Claims denials for out-of-network therapeutic alcohol rehabilitation
- Improper processing of behavioral health lab services claim

(The CID issues regulatory guidance and reminders of these requirements to the industry through official notices and bulletins. See Appendix)

II. Covered Treatments/Drugs

The CID survey reviewed coverage compliance for the following benefit categories:

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>Essential Health Benefit</th>
<th>State Mandate</th>
<th>Covered by Carriers Surveyed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Acute Inpatient</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Residential Treatment</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Routine Outpatient</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Substance Abuse Detox</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Chemical Maintenance Treatment</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>
Specific Categories of Covered Drugs

Smoking Cessation

Most carriers covered both bupropion and Chantix as well as a form of nasal spray treatment. Most carriers also indicated coverage for nicotine gum, patches and lozenges, but in some cases did not specify brand names. Of those specific drugs listed, coverage included Zyban, Nicorette gum and lozenges and Nicoderm. Some of these were covered under the medical portion of the benefits rather than under prescription drugs.

Alcohol Deterrents and Anti-Craving Medications

All carriers provide coverage for alcohol deterrents and anti-craving medications. Specific drugs varied among carriers but included acamprosate, acampro, Antabuse, Campral, disulfiram, and Vivitrol. Some of these were covered under the medical portion of the benefits rather than under prescription drugs.

Abuse Deterrents and Reversal Drugs

All carriers covered naloxone in both injectable and nasal spray forms in the category of opioid reversal agents. In addition, some carriers covered naltrexone and Revia. Some of these drugs were covered under the medical portion of the benefits rather than under prescription drugs.

In the category of opioid dependence treatments, all carriers provided coverage for Bunavail film, buprenorphine and suboxone. These were often listed in various doses. Other drugs covered under this category varied by carrier but included diskets, Dolophine HCL, Vivitrol, Zubsolv, naltrexone, Revia and Probuphine Implant Kit.

Methadone is a covered benefit that is generally provided as an outpatient treatment rather than as part of the prescription drug benefit and as a result it is not listed under prescription drug coverage. Chemical maintenance is a mandated benefit that is covered under all plans.
III. Access to Treatment

The CID works to ensure that the contractual promises carriers make to policyholders are honored. Under state law, all major medical policies are required to cover the diagnosis and treatment of substance abuse disorders.

Utilization Review

All carriers employ some type of utilization review (UR) or case management for certain covered services. The CID reviews prior authorization requirements under each policy to ensure compliance for mental health parity for non-quantitative requirements. Carriers cannot subject all mental health services to prior authorization if comparable medical services are not subject to prior authorization.

The CID licenses all companies that provide utilization reviews and those UR companies are subject to regular examination by the CID Market Conduct Division. Our Market Conduct reviews - routine and targeted – identify issues with UR companies and require corrective action to ensure there is:

- Clear demonstration of consistent use of the appropriate clinical peer in all appeal determinations
- Clear demonstration of specific medical necessity criteria for prior authorization and grievances

The CID collects and reviews data on claims denials separately for both medical and mental health/substance abuse services and publishes the findings in the annual Consumer Report Card. Additional data was collected 2016 Consumer Report Card based on recommendations from the 2015 Behavioral Health Working Group.
**Survey Findings for Prior Authorization & Limits**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Preauthorization</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital for substance abuse, mental health or medical</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Residential treatment</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Intensive outpatient</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>Varies by carrier</td>
<td></td>
</tr>
<tr>
<td>Emergency Services</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Prescription drugs used to treat overdoses</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Prescription drugs</td>
<td></td>
<td>Most coverage is a 30 day supply for one copayment</td>
</tr>
<tr>
<td>Home health visit*</td>
<td></td>
<td>80 visit limit in a consecutive 12-month period</td>
</tr>
</tbody>
</table>

*Plans surveyed had limits of either 100 visits or provided unlimited visits*
IV. Cost-Sharing Requirements

The CID surveyed all carriers for a breakdown of their cost-sharing by deductible, coinsurance and co-pay levels. Co-insurance is usually the percentage of what the carrier and policyholder will pay, i.e. 80-20, 70-30. A co-pay is the dollar amount a policyholder would pay for a service, i.e. $30 for an office visit. Cost sharing limits are determined by state law, CID guidelines and the Affordable Care Act (ACA). All cost sharing is applied to the maximum out-of-pocket amount that a policyholder must pay.

Affordable Care Act

There was consistency in the levels of cost-sharing largely because the ACA requires that plans meet specified actuarial levels for the bronze, silver, gold and platinum plans. This does not include grandfathered plans, those plans sold before March 23, 2010 when the ACA was enacted.

Maximum out-of-pocket deductibles for an individual was $6,850 for 2016. The ranges of deductibles for grandfathered and non-grandfathered plans surveyed was $0 to $10,000.

State Law

Home health care cannot be subject annual deductible of more than $50 unless the plan is offered with a health savings account. The coinsurance for home health care cannot exceed 25 percent.

CID Guidelines

Co-insurance and co-pays must not exceed 50 percent of the allowable cost of a service. The CID regularly reviews these limits and requires insurance companies to revise them when warranted. Cost-sharing requirements are outlined in Bulletin HC-109.
Cost-sharing Ranges

The CID survey determined that carriers were in the allowable cost-sharing ranges. The amounts shown below are those paid by the policyholder:

<table>
<thead>
<tr>
<th>Service</th>
<th>Coinsurance (%)</th>
<th>Co-Pay ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>0-50</td>
<td>0-50</td>
</tr>
<tr>
<td>Inpatient Stay</td>
<td>0-50</td>
<td>0-500/day, up to 2,000</td>
</tr>
<tr>
<td>Residential treatment</td>
<td>0-50</td>
<td>0-500/day, up to 2,000</td>
</tr>
<tr>
<td>Partial hospitalization: Inpatient facility</td>
<td>0-50</td>
<td>0-500/day, up to 2,000</td>
</tr>
<tr>
<td>Partial hospitalization: Outpatient facility</td>
<td>0-50</td>
<td>0-50</td>
</tr>
<tr>
<td>Intensive outpatient</td>
<td>0-50</td>
<td>0-50</td>
</tr>
<tr>
<td>Routine outpatient</td>
<td>0-50</td>
<td>0-50</td>
</tr>
<tr>
<td>Substance abuse detox</td>
<td>0-50</td>
<td>0-500/day up to 2,000</td>
</tr>
<tr>
<td>Chemical maintenance</td>
<td>0-50</td>
<td>0-40</td>
</tr>
<tr>
<td>Home health care</td>
<td>0-25</td>
<td>0-25</td>
</tr>
<tr>
<td>Emergency room</td>
<td>0-50</td>
<td>0-200</td>
</tr>
<tr>
<td>Urgent care</td>
<td>0-50</td>
<td>0-75</td>
</tr>
<tr>
<td>Brand Prescription Drugs*</td>
<td>0-50</td>
<td>0-60</td>
</tr>
<tr>
<td>Generic Prescription Drugs*</td>
<td>0-50</td>
<td>0-5</td>
</tr>
</tbody>
</table>

*Some carriers cap the level of cost sharing for prescription drugs when coinsurance is applied to limit the amount of cost-sharing for high-cost drugs. The caps reported in the survey ranged from $5 to $1,000 per prescription.
V. Industry Innovation & Response

Consumer protection is the prime mission and ensuring that Connecticut has a robust competitive market is one prong of that. The CID regularly communicates with the industry to learn about new products and new approaches to address various issues, such as the opioid crisis.

In October, the CID sponsored a public forum with major carriers to learn more about their programs and strategies to curb opioid abuse and provide coverage for treatment for opioid addiction for their policyholders.

Three health insurers, Aetna, Anthem and Cigna, and two property and casualty insurers, The Hartford and Travelers, participated. Each company has a number of programs in place and each highlighted a different program which included:

- A focus on reducing prescribing by “Super Prescribers”
- Education programs for claim handlers, providers and injured workers on the use and abuse of opioid medication
- An in-home clinical substance treatment program which uses a multi-disciplinary treatment team led by a psychiatrist and includes nursing, therapy and peer recovery support
- A patented predictive model to help injured workers avoid chronic pain and opioid use.
- Coverage for medication that reduces the craving for narcotics, such as suboxone, which is similar to methadone but can be taken at home and reduces hospitalizations and re-entering treatment programs.
VI. Conclusion

Combatting opioid abuse in Connecticut requires all stakeholders to leverage their expertise, regulatory authority and innovation to help individuals and families struggling with the impacts of additions.

Connecticut has strong laws and regulations to ensure that consumers have access to insurance coverage for treatment of substance abuse. We must continue to work to destigmatize opioid addiction and recognize it as a chronic condition which may require lifetime treatment.

This report confirms that treatment for substance abuse disorders is a mandated benefit and covered by all carriers in the state. However, it is critical that the CID hears from individuals if they encounter issues accessing treatment so that we can utilize our regulatory tools, expertise, assistance and advocacy to ensure policyholders can access the benefits and coverage to which they are entitled.

For any concerns, contact the CID at:
- Email: insurance@ct.gov
- Phone: 800-203-3447
Appendix

BULLETINS AND NOTICES

January 2, 2014: Mental Health Parity Annual Compliance Survey

February 5, 2016: Bulletin HC-109: Maximum Cost Sharing

March 7, 2016: Health Insurance Rate Filing Submission Guidelines

May 31, 2016: Health Insurance Coverage for Pain Management

OTHER RESOURCES

Consumer Report Card on Health Insurance Carriers in Connecticut

Consumer Claims Toolkit for Navigating Behavioral Health and Substance Abuse Care

CID Mental Health Parity Resource Page

Market Conduct Examinations

CID OPIOID SYMPOSIUM – October 14, 2016

Symposium Video

The following Power Point Presentations are attached below:

- Aetna Presentation
- Anthem Presentation
- The Hartford Presentation
Aetna’s Opioid Superprescriber Initiative

Daniel Knecht, MD MBA
October 2016
The Opioid Epidemic is a National Crisis

Key Statistics

165,000
People died from prescription opioids from 1999 to 2014

~2.5 Million
Americans abused or were dependent on prescription opioids in 2014

78
People die from opioid-related OD (prescription opioids and heroin)

~4X
amount of Rx opioids sold since 1999
The Prescription Pad is the Main Source of Opioids

Source: SAMHSA, 2009 and 2010 National Survey on Drug Use and Health

1Other category includes wrote fake prescription, stole
“Based on an analysis of our pharmacy claims data over the past year, you have been identified as falling within the top 1% of opioid prescribers within your specialty.”

Harold Paz, MD MS
Executive Vice President
Chief Medical Officer, Aetna
CDC Checklist Included with Aetna’s Outreach

- Designed by CDC for physicians to better manage chronic pain
- This guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care.
  - Guidance on when to initiate, continue and discontinue opioids for chronic pain
  - Information on opioid selection, dosing and duration
  - How to provide risk assessment and addressing harms of opioids
A Data-Driven Approach to Identifying Opioid Superprescribers

1. Identify high prescriber specialties: Internal Medicine, Family Medicine, Surgery, Rheumatology, Neurology, OB/GYN (excluding oncology, anesthesia etc.)

2. Rank physicians based on refill-to-fill ratio...
   *Extended opioid exposure places patients at higher risk for adverse outcome*

3. Filter out physicians who prescribed less than 12 opioid Rx over past year

4. Narrowed in on top 1% by specialty...
   *An average ratio of 4.5 refill-to-fill compared to that of 0.3 for any physician who prescribed*
Superprescribers: By The Statistics

All US states (and Washington DC) had physicians on the list. The states with the top 5 highest number of superprescribers:
1. Pennsylvania 136 (15%)
2. Missouri 87 (9%)
3. Florida 78 (8%)
4. North Carolina 52 (6%)
5. Utah 45 (5%)
Next Steps…

Monitor Superprescribers
- Re-analyze data to ascertain impact
- Intervene on refractory Superprescribers

Outreach to Dentist Superprescribers
- Analyze data on opioid prescribing
- Seek partners in dental community

Advanced Outreach
- Flag to members who have overdosed
- Promote behavioral health support
Substance Use Disorder Treatment

Steven Korn, MD
Behavioral Health Medical Director, Anthem Northeast Region
October 1, 2015 Anthem contracted with Aware Recovery Care

Contracted provider of in-home clinical substance treatment for chronic substance use focusing on relapse prevention

Multi-disciplinary clinical treatment team led by a Psychiatrist and includes nursing, therapy and a peer recovery support specialist specifically assigned to the member

Utilization
- 67 admissions to date
- 14 early discharges
  - 9 related to severe psychiatric co-morbidities or need for a higher LOC and 5 due to non-compliance and lack of motivation

Success stories
- A 20 year old woman with multiple treatment episodes including several months in RTC, all unsuccessful, now sober for 10 months
- A 55 year old man who began drinking at age 13. No previous treatment other than IOP, no periods of sobriety. Now sober 8 months.
SUD Treatment Update - Other

• Wheeler Clinic In-home substance use program
  • Focus on SUD treatment in teens / young adults with their families

• Out-of-Network Providers
  • 2017 FI policies will require licensure and accreditation language for residential facilities
  • Implementation of an OON BH facility fee schedule equal to the median rate of participating providers

• Toxicology Expenditures – Drug Screening
  • Adoption of CMS updates for presumptive and definitive drug screening
  • Bundled procedure codes with annual accumulators

• BH Supports and Resource expansions
  • Live Health Online – Psychology available to Anthem members
    – Psychologists and LCSWs appointments within 4 days
    – Appointment scheduling available thru 11 pm and includes Saturday and Sunday availability
  • myStrength – online cognitive behavioral therapy
    – Available to buy-up BH Resource accounts and EAP members
Oksana Kamyshin
Pharmacy Strategy Manager
October 14, 2016

OPIOID MANAGEMENT STRATEGY
Opioid Management Strategy

Education

Drug Review Program

Holistic Approach

Comprehensive Peer Review Program

Alternatives to Opioids
**Claim Handler Education**
- Monthly series presented and taught by medical director
  - Opioids, Delayed Recovery, Pain Interventions
  - Resources available for claim handlers
  - Nurse Case Managers, Drug Review Nurses

**Injured Worker Education**
- Letters educating injured workers on the potential dangers of taking opioids and provide safety tips related to opioids

**Provider Education**
- Educational letter on Fentanyl
- High utilization of Opioid Analgesics
- Long Acting Opioid letter – encouraging physicians to adhere to prescribing guidelines
- Morphine Equivalent Dose Alert letter
| Targeted for claims with high opioid utilization | Peer to Peer conversation takes place in order to reach an agreement | Focus on weaning opioids and provide most appropriate and safe treatment for Injured Worker |
Alternatives to Opioids

- Functional Restoration Program
- Cognitive Behavioral Therapy Program
- Internal Coaching Program
iRECOVERSM

10-week telephonic coaching program to prevent delayed recovery and return claimants to function by

1. Returning locus of control
2. Educating
3. Teaching coping skills
Feedback

• “There’s light at the end of the tunnel.”

• “I feel confident going back to work. A good part of this is due to my participation in iRECOVER.”

• “Insurance companies get a bad rap these days and the fact you’ve put this program into play is wonderful.”

• “I think what you do, is probably as important as medical treatment.”
Impact of Opioid Management Strategy

• Since 2015
  – Opioid utilization on claims dropped by 25%
  – Opioid utilization on Connecticut claims dropped by 37%
  – Average MED per claim decreased by 9% on Hartford claims