
SANDY HOOK ADVISORY COMMISSION

MARCH 22, 2013

9:30 A.M.

Legislative Office Building

Hartford, CT

SCOTT JACKSON, Committee Chair
ADRIENNE BENTMAN
RON CHIVINSKI
ROBERT DUCIBELLA
TERRY EDELSTEIN
KATHLEEN FLAHERTY
ALICE FORRESTER
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BARBARA O'CONNOR
WAYNE SANDFORD
HAROLD SCHWARTZ

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AGENDA

I. Call to Order

II. Behavioral Health - Increasing Public Awareness & Decreasing Discrimination

Kim Pernerewski, National Alliance of Mental Illness, CT

Louise Pyers, Executive Director - Connecticut Alliance to Benefit Law Enforcement (CABLE, Inc)

Deron Drumm, Executive Director - Advocacy Unlimited

Bryan V. Gibb, Director of Public Education - National Council for Community Behavioral Healthcare (Mental Health First Aid)

III. Access to Mental Health Care

Deputy Commissioner Anne Melissa Dowling, State Department of Insurance

Vicki Veltri, Connecticut Healthcare Advocate

IV. Assessment and Management of Risk

Marisa Randazzo, Managing Partner - SIGMA Threat Management Associates

V. Other Business

VI. Discussion

VII. Adjournment

MR. JACKSON: So before lunch, we will move into our final morning presentation, and we certainly want to thank Deron Drumm for his scheduling flexibility. Mr. Drumm is Executive Director of Advocacy Unlimited.

MR. DRUMM: Good morning, for two more minutes, I think. My name is Deron Drumm. I'm very happy to be here. I want to thank you all for the service you're providing to this -- residents of Connecticut. It's really important. I particularly want to thank the Governor and Commissioner Pat Rehmer for collaborating to make sure someone who's lived experience is on the panel. That means a lot to us.

I personally and on my behalf and many others want to thank Kathy Flaherty for standing up and self-disclosing and being here for us. It means an incredible amount to us. I am the executive director of Advocacy Unlimited. Our organization does two main things. We do, of course, advocacy; we look at issues through a human rights lens. We look at human rights violations. We look to change the mental health system and add and do what we can to make things better in Connecticut. And we do that in a lot of ways.

The other thing we do is we teach, train about alternatives to the current mental health system,

wellness tools. Peer support which we heard in context of police officers, we do in context of people who are experiencing emotional stress or crisis. We hold the State of Connecticut certification for peer support, so if you want to work in the mental health system as a peer specialist, you go through our program, take an exam and get certified. And I'll talk a little bit more about alternatives later.

I am a person who self-identifies as having experienced, lived with, through what is commonly called mental illness. I experienced extreme emotional states. Being here I think it's important that I kind of tell what I think are good ideas moving forward in my humble opinion through kind of my stories. I hope you bear with me; it's not easy to tell some of the things I'm going to tell, but I think it is important.

I'm someone who as a child suffered a lot of the stress. I'm 41 years old, so when I suffered all this stress, there was no computers to Google things. I didn't know what it was. I went through you a lot of different things. And I'm going to give some examples which I don't always do because I think it is necessary.

I had rituals and routines I went through every day. I -- I rubbed my tooth -- my tongue against my teeth probably a thousand times a day as a

kindergartner, first-grader. My mouth would bleed, and teachers would say, "What's going on?" Of course, I would say I bit my tongue. I did that so my parents wouldn't die, you know, which my brain was telling me. I had a lot of these things.

I think one example I was telling one of my colleagues it stood out to me in context was kind of this link between mental health and violence which I think simply does not exist. I remember playing with the neighbors' kids; probably I was eight years old. And there was a bee in the room, and one of the girls in the room was saying, you know, "You should kill it." I killed it. I probably spent months punishing myself, you know, for killing one of God's creatures, waited for the wrath to come down on me.

And I experienced all these things in complete silence, so afraid to talk to my family about them, so afraid to talk to anyone about them. I didn't know what to do, and I spent years dealing with different things, many different things that were very distressful for me. When I finally learned to drive, it was just an amazing nightmare. I thought I hit people when I drove. I would turn around and look, look in the woods, look at the news the next day to see if there was a hit-and-run.

And through all this, I had -- I had to

cover it up. So when I was at my girlfriend's house, and I ran out to get pizza, and it took me 45 minutes to come back because I -- again, I had an experience, I thought I hit someone, I had to go through all that. And I had to say I ran into someone, I did this, this happened, this happened, all of these experiences.

When I'm with friends walking through a door, and I have this -- this feeling that I need to walk through it again. I told people I forgot something, just doing things to make sure, you know, I don't appear, quote-unquote, crazy the whole time not having any clue what I was going through.

So we had the -- kind of the distress I'm in, some would call symptoms. We also have all these effects of my trying to cover it up for years and living with it in silence. I finally could not take any more in my late teens, I simply couldn't, and suicide seemed like the option for me. In what was the greatest moment of courage in my life, the date I finally asked for help, I went to a mental health provider -- I was brought to one. You know, and I was diagnosed over a couple visits, and I was told I had a brain disease and I would need psychiatric medications the rest of my life based on a chemical imbalance theory that people were using back then.

It's a dark time. I wanted to be doing things. I wanted to be good at something, so I thought I can be a good patient. So I did what I was told. I followed through. My life became about taking my medications. And I can tell you in coll -- it was probably late teens going into college, two weeks after I started my sex life, gone for a long time. It was a big trade-off, and I wasn't feeling any benefits of them. Sleepless nights, many side effects, many different psych meds. I think I spent -- 19 I've taken in my life.

And my life became about managing symptoms, of not feeling bad. You know, instead of feeling good, it was striving to not be sick, to worry looking for symptoms living every day in fear of what would happen instead of striving for happiness and meaningful life. I did this for a lot of years, and it was a very tough road for me. As I mentioned, I had many side effects I dealt with.

I finally experienced kind of that feeling of being beaten and broken. I just -- it wasn't happening for me. It was too hard for me. I -- My experience was just too hard. And, by the way, my diagnosis went from one to two to three over this time. And I basically gave up and -- I gave up and thought maybe I can just go off and kind of do my own thing. And

I find some peace in places that I shouldn't have found like Mohegan Sun, places like that, bars.

I became incredibly addicted to gambling and other things and kind of went down this spiral of incredible despair, emotional stress, extreme states, addiction. I caused incredible damage in my life; I hurt people around me. I ended up in a psychiatric hospital, spent some time there. Got out of there just thinking that suicide was the only option, my life was over. Ended up in a rehabilitation facility that worked on co-occurring disorders or of air quotes; I don't really like labels but dealing with emotional stress and addiction.

And I got there, and I remember the first day, you know, I was just again so beaten, so broken, I didn't feel I had any reason to live, didn't think I should because I had hurt people. So first day someone came to me and said, "Are you ready to start your life over?" And I said, "Well, I can't. I did these things, and I have this brain disease, and just my life is -- is over. I'm just waiting to die."

And he said to me "See this scar on my shoulder?" And I said, "Yeah." He said that's where I was tackled by a police officer and got cut when I was robbing a bank." He said, "See this scar on my head?"

He said, "That's where I shot myself in the head when I thought I had no reason to live anymore." And he said, "You see these pictures? This is my new family. This is my house; this is in Florida." His house is near the beach. He told me his life he had now which sounded incredible. And he said, "Now I'm going to tell you how I did it."

And he started to share his story with me, and from that time over the next several -- few years, so many other people came to me and told me things that could really help me, tools. And mental health professionals, people who have been through comparable experiences, a host of people came to me. And I listened, and I learned. But the first thing I need to learn, I need to understand, this is my life, my body, my choices. And I have to be responsible and accountable for my life.

If I was going to change, I was going to have to take this very seriously and know I had to do everything I had to to be well. I learned the power of nutrition both ways, to feel good, to be well, also to be really not well. GMO's, gluten, processed sugar, alcohol, what they do to our systems and bodies, particularly people who experience extreme states like myself.

I learned that through the years of covering up my emotional distress and covering up my addictions, I had become very manipulative, very controlling, didn't know that. I had to learn in time that I do a lot of things to get better, I become very defense and deflected things. And I had to learn to work through all those things. And it was very hard, and there's things I'm still working on and will always work on.

I learned that it's okay to be emotive, it's okay to have bad days. I got to where I am, and I know so many of my friends who -- who've gone through the same feeling where you don't -- if you don't -- if you feel anxious, you feel not well, you think you need to go do something about it, go take a pill, go get a -- take a drink. I learned to just be okay with having a bad day, to know that tomorrow will be better. And it's a really powerful thing for me to understand.

I learned that, you know, I can believe in myself because I had no self-esteem for so many years. I went to school, college, law school 19 years. I don't think I ever raised my hand; I don't think I ever voluntarily participated in anything. And the 19 years I got credit for, it took a lot longer with all the stuff I was going through, but now I'm here speaking in front of

you.

I speak all over. I spoke in seven states. I was asked to speak in London, and I couldn't even raise my hand in a class of 10 people. All through the things, the wellness tools I've worked through and incorporated into my life, structuring my life, my days very intentionally; I do the same things every day. I wake up; I pray; I meditate; I do yoga. I have the same things I do every day. I need to do that to be well for me. Do I think what I do would work for everyone? Of course I don't, but other people shouldn't assume that what they're talking about would work for me either.

My friend Will Hall who presents a program or a book on how to come off psychiatric medications, he's done really well; he was asked by the American Psychiatric Association to present a couple of months ago. He's gotten really good response in follow-up meetings with them. He talks about the mental health system as a big toolbox, except when you open it up, there's just hammer after hammer after hammer. It's time we get some new tools in that toolbox.

I can look at my experience, and I spent so much time reflecting and thinking over everything I've gone through, and I take so much responsibility for my life, believe me. But there's things that I've dealt

with that could have been better. When I reached out for help to people, I paid for help; it should have been better. So I spend a lot of time thinking what can I do better, what can my agency do better based on my experience, based on the 11 folks I work with who also self-identify with comparable experiences to mine.

And we've come up with a lot of different things. And one thing I think we had to address early is a psychiatrist friend of mine who's written many books, him and I had a long conversation. I talked about a lot of things that worked for me, and he agrees, you know, those are great things. But he said if you took a hundred of his patients, maybe one would do them. And he's got to help people; this is kind of the way it is, the way he does things. And I thought about that, and I understand that, I do because I know this country is about quick fixes. So if you go in and you're in stress and someone says "Take this bottle of pills" or this do this whole program, I understand what most people are going to pick.

So we worked on things in our wellness class, things like transformative habits, how to slowly add things to your life. We have people on our staff who started walking in place, running from like here to the wall. She's now a marathon runner. You know, we have --

how do you incorporate these things? I started meditating a minute a day, and that's all I could do. And I incorporated these things over time.

You know, gluten went for me, alcohol and gambling first, of course, but then, you know, gluten and then processed sugar and many other things, artificial sweeteners. And slowly things have gone from my diet over time. I'm using these kind of how to incorporate these habits into your life so it becomes easier for you. So we teach about how to do that. And, of course, we teach what those positive transformative habits could be. And people can choose whatever they want including just medication. We support whatever people choose as long as they're given options. If you're given options and your choice is kind of the standard mental health system thing, that's fine, we support you.

But you've got to be given options. Given one form of treatment which in this country usually is medications or you can go on your way and be in your crisis, that's not choice. It's not choice. Coming in and say, okay, you take this medication but you also should really look into doing this, looking to working out. You should talk to peers about your experiences. Like the police officers mentioned, they're incredibly profound to talk about these experiences with people who

have gone through them.

Now, I know my experience, what I went through. But we have to be honest. The empirical outcomes of the mental health system in this country are tragic. 2006 medical directors did a study that show that people accessing public mental health services are dying 25 years younger. Social Security disability is adding 850 people a day for mental health issues. And everything I say, I have stats for all. Anything you want, just let me know.

And, again, these studies aren't ours. They're done by mental health providers; they're done by other agencies, Ivy League schools. And nothing -- our movement -- we don't have any money; they're not our studies. 16,000 kids were on Social Security disability for mental health reasons for 1987. It's over 600,000 right now.

Now, do I think mental health experiences are real? Of course I do. I told you about my childhood; they're incredibly real. If I don't live the life I'm living, I know what's in store for me. I understand that extreme states can cause incredible suffering, but I also know the human brain is amazing how it manifests itself and kind of believes what you tell it or what people tell you. So when people tell you you're

broken and you're probably going to be on Social Security disability for the rest of your life, they tell you you should lower your expectations in life, we tended to believe it, and we start to think that way.

That's why the self-responsibility thing is so big for me because you almost get to a point where it's well, you know, I'm too sick to do that, I have mental illness. Man, that's dangerous. We don't want to do that; we got to empower ourselves and folks are going through this. People at I work with -- You've heard some of my story. People on Social Security disability were over a hundred pounds overweight, consider themselves, quote-unquote, mental patients who are now doing amazing things with their lives. It changed everything.

I always ask a lot of questions to kind of learn and grow as a person and grow in my role. And one thing that's been really clear to me -- now, my experiences I don't remember -- I don't know if my experiences are genetic. I don't know. I don't think anyone knows. I don't remember not having some difficulties.

So I've been asking a lot people to kind of look into that. Just based on talking to people, there's a lot of people that are, quote-unquote, considered mental patients or self-identify that way who

are just example I give off a woman who has a very healthy, meaningful life in all -- on all accounts whose beloved husband dies and seeks help from her doctor -- 75 percent of psych meds are prescribed by family physicians -- and is given antidepressants. A month later, very sad, her husband dies, she's given more, can't sleep, is given Ambien and eight years later 80 pounds overweight, has diabetes, now considers herself a mental patient. There's no biological basis there. There's no chemical imbalance there. And this is so common.

So when you act, I hope you will come from one understanding not of fear. What you're doing, what you recommend, what they do here is not going to impact Adam Lanza; he's dead. It's going to impact thousands of millions of people, people that are lawyers and doctors and judges and kids. You know, they don't to experience this, don't need to be labeled and hurt, need to be embraced.

We talking about crisis, how to deal with people in crisis. It's so important how to just be with them and let them be in crisis. A crisis is often the window to incredible opportunity in people when their true potential comes out which is what happened to me. People asking for suicide is a very important thing.

Someone tells you they feel like killing themselves, they're staying they can't take their experience or they want to change, that's powerful. We shouldn't be looking down at that. How we address suicide needs to change in this country.

And we talk about evidence-based, I think I've heard at least twice today. There's probably eight people with me. I was supposed to testify on April 12th; I would have packed this room, but two days' notice and some things the last few days. That or the evidence, folks have been labeled with many different diagnoses that are doing incredible jobs, doing incredible things. Sitting to my right, I mean, that's the evidence that this stuff works.

So we teach the class, we -- looking at yoga and being present and being mindful. We teach a lot of that and the self-discipline and how to move beyond trauma, how to celebrate our uniqueness. And there are classes we teach at Advocacy Unlimited, and they're so important. We teach them in a very peaceful way. And like I'm an advocate and an activist, and I have kind of a different tone maybe to my voice depending where I am. Some people -- a lot of people know; Dr. Griffith knows. We were been on a panel together recently.

But we teach these -- it's all about

celebrating who you are. I don't tell people to come off medications. I had some that helped me. It's not about that; this is not anti. This is trying to support people and let people grow and find ways to be the best they can be and enjoy their human experience to the best extent possible.

And that's what we do, and these classes are really wonderful to go. And lot of you here have done those kind of things. And a lot of you here besides Kathy dealt with emotional distress in your lives. I mean, she talks about it, but we know she's not alone, not on this panel; she's not. Anxiety, stress, depression, sadness, I mean, that's a lot of us.

Now, do some of us go to extremes and need some tools, yes, of course. And there's a lot of things available; it can't just be one. I go to every -- I've been to every provider, I think, in this state and I talked to people, and there's some great people working, everyone of them. But it's always about medication in most places. There are some options here and there but usually it's about first and foremost medication. Let's look beyond that. And if it's just medication, we've got to have many other things; it's not enough.

Parents call me and say, "I'm afraid to ask for help for my children because I'm afraid of D&D,

diagnosis and drugs, for my kids." And they're scared of that, and I like to tell them they shouldn't be, but they should be. My third diagnosis I saw a psychiatrist for 11 minutes and was told I was bipolar, 11 minutes. Years later I had open heart surgery, and that record came to the doctors, and they saw the bipolar disorder label in my records, and the shift in the way they treated me was unreal and to people in my family watching. It was unreal.

The stigma of labels, they are very real. We got to have -- Finland has programs where they have front line, we talk to people, be with people, listen to people, see where they're at, their experiences. And then if they feel, okay, now they need to go and see a psychiatrist, a doctor, that's a great philosophy. We want to --

I tell people my experience in psychiatric hospital. I was there, and we did nothing all day, nothing. And this is not that long ago; it's not 50 years ago. I sat in a bed; I'm guessing that they were waiting for medications to kick in. I don't know. I was in that rehab facility. I was working on both my emotional stress too and addictions. They worked me all day long, groups, 12 steps, one-on-one therapy, biofeedback machines all day long, probably 15 hours a

day we worked on stuff.

And I learned how to be me. I learned how to move forward. I learned how to move towards a meaningful life. If someone in my family is struggling and going through emotional distress, I would not hesitate a second to send that loved one to that rehab facility, not a second. In fact, I can't wait to go back and visit; I just haven't been able to fit it in. That's how important it was to me. I would die before a loved one went to that psychiatric hospital; I would die first before I allowed that to happen. That's how bad it was.

So parents that want loved ones or kids to seek treatment, they should feel like it is that kind of environment where there's options, where there's choices, where you feel good about it. When you get well, you want to go back and thank them. And you feel okay referring people to them. I'm not sure that exists very much in this country; I really don't, and it should.

I enjoy my life. I love my job. I think I'm a valuable member of society. I think I contribute. I didn't for a long time. I do it with -- with a very -- mentioned the lifestyle I live. I think people would have told me in the system, they've heard this that it wouldn't be possible. If I told them, this is what I want to be, I think I would have been told it's not

possible. I could have told the people in the rehab center that I want to be, who knows, some -- pick the position, they would have said, "Okay, let's figure out a plan." It was amazingly supportive.

And the power of peer support, it's interesting to hear from the police officers' standpoint. But talking to people with -- about trauma and things they saw and things they experienced and who have gone through it is really, really profound, and we have to have more of that in this system. It's really important, and it's not that expensive.

The problem is we got to make sure peer support specialists working the system have their own discipline, you know, that they're not influenced or co-opted by the current system. They got to be allowed to do their jobs. That's really important.

And we look at the alcoholism. Remember in the 18 -- don't remember, but you heard or read 1800's or early 1900's people died in psychiatric hospitals of alcoholism. Connecticut Valley Hospital, people died there of it. Bill Wilson, the founder of AA, and others took into the community people with comparable experiences, saved people's lives, saved millions of lives over the last 70 years. It's amazing what peer support can do. We need to have it in our mental health

system here in Connecticut.

We have some. Commissioner Pat Rehmer's trying but there are road blocks, and we need to have -- we need to have the road blocks removed. I know it's lunch time, and people want to go, so it's just -- it's really important to me that we look at other options. You know, the word "treatment" is very misleading in this country. It often means just drugs. Is that treatment? Might be treatment for pneumonia; it's not a treatment for emotional experiences.

I told you the things I had, the covering up. How could a pill fix that? The years lying to cover up my symptoms or whatever you want to call them, pills can't fix that. We need so much more therapy modalities, so many other things besides that. Do I think psychiatry has a place? Of course I do. But it's a well-rounded approach we need to all this, and that's not what we have right now. We need more than what we have. We need to do better as a country. We do. Thank you, everyone.

MR. JACKSON: Thank you for your testimony, Mr. Drumm. Questions from the panel? Ms. Flaherty?

MS. KATHLEEN FLAHERTY: This is really more comment than a question, and I'd like to thank Deron for coming and sharing his story and really everybody who

came this morning. And for those members of not the mental health group that helped put together all these upcoming weeks on mental health, just want to let folks know if it was not abundantly clear by the presenters this morning that really the purpose of this morning's discussion was a presentation on mental health by people with lived experience in order to increase understanding of the experience of people living with mental illness and their family members and what it's like to experience discrimination, some of the education programs that are available to combat stigma and what are some of the particular issues faced by families, the barriers that can lead people to choose not to engage with services, challenges involved with raising children with special needs and, really more importantly, the ways a community can come together and effectively interact with a person living with a mental health issue.

And I'd really just like to thank Deron especially and -- and the folks from the police department too. I'm glad we were able to talk about peer support for the -- for our first responders but really talking a lot about the importance of peer support for people living with mental health issues. As Deron knows, it's something I'm involved with too, so thanks.

MR. JACKSON: We happen to be the same

age, so we experienced big events at the same time, and I'd be interested in your perspective. In Columbine, an analysis of the police response to Columbine changed the way that police officers respond to an active shooter in a way that has saved lives.

MR. DRUMM: Mm-hmm.

MR. JACKSON: Have -- (A), have you seen any significant enhancements based upon any tragedies big or small; and, (B), you mentioned --you mentioned the Finnish intake model. You mentioned the incorp -- the incorporation of transformative habits into a -- into a treatment module. If there was -- If there was -- If there was one specific -- if you read our fine report and said, "Aha, they got that right," what would it be?

MR. DRUMM: Well, you know, my -- I heard mentioning the Columbine and other tragedies, I mean, quickly my brain said, no. But that wouldn't be fair. I think a lot of the trauma things, I think Dr. Schwartz talked about vicarious trauma, I think we've gotten better in that arena; I do. The one thing is peer support; it really is peer support, people with comparable experiences coming in and helping others.

And I tell you in our class, we have people with PhD's that feel they want to do it this way, they don't want the clinical rules; they want to be able

to talk to people on that human, one-to-one level, and they want to be able to disclose the most -- first and foremost. So we have -- we have people that were attorneys; we have people -- we have all kinds of walks of life, every -- so much diversity in our courses, people that know how important this is. Now, they don't all want to work in the system, but they want to learn these skills so they can help people in the community. And so I think the peer support is incredibly important. Sure.

MR. JACKSON: Anything else?

Ms. Forrester?

MS. ALICE FORRESTER: Thank you so much for sharing your story. You know, our clinic was started by a man who was locked in up CVH for many years. And when he came out, he wrote a book, and despite living with mental illness actually, you know, spent the rest of his life trying to advocate for the study and try to change the world's approach in addressing stigma.

I think the thing that I heard the most from you and I heard all this morning was the incredible value of community. You know, your work on peer-to-peer support, the mom with NAMI of finding other mothers who had this experience. And I wonder how -- how do you think -- what kind of recommendation do you think we

could make as a commission around supporting community development? Would it be specifically to increase peer-to-peer programs or -- I don't know. Just -- Just what do you see as the future that would be helpful?

MR. DRUMM: Well, thank you. And I very much admire Mr. Beers so -- the -- For you guys, I think the peer support, I think that will spin off in the community like it has for AA. I think it's -- in time. Frankly, our community needs our Bill Wilson. Hopefully someone can get that done for us.

But as far as kind of the stigma and everything we got to get away from the labels, all the labels, and that is so huge. And I don't know how you recommend that, and I don't think it's possible. I mean, of course, I don't know if you would. We got to stop labeling people right away, and it's so vast, and it's so scary.

And we got to really under -- have people -- you got to let people like me testify; you know, there's people much better than me who've lived experience that should be here doing this that are much more articulate than me. But it's important to understand that we are humans. You know, we live right near Mark Twain. He talks about all the emotional stress he had. He talked about how walking probably on the

ground under this building, how walking helped him, laughing with friends.

Abe Lincoln was on suicide watch by his neighborhood, became president of the United States, and many credit him for ending slavery. I mean, these experiences are all things we go through to different levels. We can't these quotes, "the mentally ill" in the newspapers, "the deranged people" because it's all of us. And it is; we all experience things. And if we haven't experienced extremes, we could.

I told you the example with the trauma, it could happen to anyone this afternoon, God forbid, and then you're experiencing it. So getting away from the labels and the name-calling. You know, what's scary to me, I know as a group, people that willing to disclose like Kathy and myself, you know, we're not a group with a lot of money. We don't have a national organization that talks for us; we don't have those things yet.

So it's easy to blame us. It's easy for big organizations like the NRA to say well, it's that or any -- or anyone. It's also easy to have panels like this, like the one Congress had in D.C. a couple weeks ago and not invite any of us. E. For Tory and others talked about what's best for us and no one thought to invite one of us. If you did that for any other group of

people, you'd get international pressure against you; you'd have people protesting outside.

You have a panel and talk about gun control without the NRA here, see what happens. But yet doing it without our voice here is so common. We fought for probably a month on that the Advocacy Unlimited to get our voice in the paper, and the Courant came through and others followed because people are saying what's best for us. Radio shows have CEOs or providers and from DMHAS, and not that their ideas aren't valuable, not that I disagree with everything, but why wouldn't you have us there?

You know, family members coming in and talking about their kids, pick on the ones and see how great they're doing, bring them in. These are adults; let them tell everyone how great they're doing, how great their experience has been. Our voice needs to be heard.

MR. TERRY EDELSTEIN: Thank you for sharing your experiences and thoughts with us. Do you know of anyone who's been helped by being in a psychiatric hospital?

MR. DRUMM: I read about someone once. Well, actually, when we were -- I know a lot that have been helped because it -- it pushed them to work harder on themselves when they got out. You know, there's

value; there's people in crisis that need that, those beds. I mean, I'm not opposed to all of that. But while we're there, why can't we work harder on things, people interact with people. You know, the psychiatric hospital I was in had a very highly paid staff kind of sitting around playing cards and reading. My rehab center didn't, and they were so active. You know, why not have people more engaged when they're in there?

No, I haven't toured all of them. But I think -- I guess it is this idea of waiting for meds to kick in, I'm not sure exactly why there's just kind of sitting around, watching TV, but they -- people need to be more engaged.

MR. JACKSON: Anything else, Terry? Thank you for your time, and thank you for your testimony. We appreciate it.

[Applause.]

MR. JACKSON: Why don't we -- Why don't we take a break for lunch? We'll reconvene at 1:00. It will be a short lunch today.

MR. JACKSON: Why don't we get started? We'll ask the commission members to take their seats. With us to discuss access to mental health care we have Deputy Commissioner Anne Melissa Dowling of the State Department of Insurance and Victoria Veltri, Connecticut

Healthcare Advocate. Thank you for joining us today.

MS. VICTORIA VELTRI: Thank you for having us here today. So am I going first?

MS. DOWLING: I think so.

MS. VELTRI: Okay. Well, good afternoon, everybody. It's good to see everyone. My name is Vicki Veltri, and I am the state Healthcare Advocate. We're here together to talk about our the various things we do in our offices and how we work together and try to improve things for the consumers of Connecticut. So I did prepare a Power Point, but we don't obviously need to go through all the slides; you have most of them. But I just wanted to talk about some of the key things.

First of all -- so I'm on my own slides here. I just decided -- you know, we could talk about a few things, give you a little bit of an overview about what our office does because I have -- I think a lot of people don't even know we exist -- the contacts -- you know, some of the facts that we are experiencing, some of our observations and some of the recommendations that came out of the report that I know -- I think Terry sent everybody already. So -- Yeah.

We put out a report a couple months ago that was pretty comprehensive, and rather than recite the entire report, it made sense to just highlight some

things. So the office of the Healthcare Advocate really is a -- it's one of these independent state agencies. And it exists to really help consumers, individual consumers to advocate for their health needs -- healthcare needs, and a significant component of that is advocacy around substance use issues and mental health issues, behavioral health in total.

So we really do focus on providing that specific assistance, helping people understand their rights and responsibilities under their health plans, helping them with grievances and appeals when coverage has been denied or billing issues, and also coming back and talking to people at the legislature or Insurance Department or DSS about systemic issues we're seeing to try to resolve them.

And so our office -- I don't know where I am in the Power Point right here. We provide -- Go back, but we provide assistance really to any resident who requests our help, and we work on all kinds of health plans. So whether it's privately insured so a state-regulated plan, whether it's an employer-sponsored plan or Medicaid, Medicare, we help people with all those plans.

Since 2002, we've put almost $50 million back into the pockets of consumers with the work we've

done. And that's about 20 -- that represents about 20,000 individuals that we've helped. And we average around 9,000 calls a year to our office.

This slide here tells you that we're the federally recognized consumer assistance program in Connecticut. What that means is under the Affordable Care Act, every state had the opportunity to develop an office like the Office of the Healthcare Advocate. And really what it means is we're supposed to do what we do now, but we do more of it because we have a few more people, so we're able to reach some more people. And we get some federal grant money to do that.

In addition, because of the Affordable Care Act and because of a state law, any time someone gets denied coverage so if they're denied coverage for a mental health service or substance use under their plan, our information must be on it even if it's not a plan regulated by the State of Connecticut. That's really important because that's instant outreach, and people get to us more rapidly.

We have the authority to -- to monitor the develop -- development of laws, to -- to analyze the implementation of them relating to health insurance, to facilitate public comment on laws; that's the reason we had that public hearing in October. And we have like a

convening authority under our statute around mental health, and that does require us to bring people around the table to talk about these subject matters that I think are in this slide, best practices in mental health treatment, compliance with the state parity laws, costs and benefits of offering mental health coverage. Although this statute refers to mental health coverage, we -- we really look at this as behavioral health because there's a broad issue here of mental health, substance use and the intersection of those two things that we see here quite often.

So in our work we collaborate, as you might imagine; we collaborate with CID quite often. We refer cases to CID. We talk about systemic issues. They refer cases to us. We work with DCF, DSS, the Office of the Child Advocate which is one of our primary partners because like us, they are somewhat of a watchdog entity too, and we see systemic issues over and over again, so we work together.

We also have started a collaboration with the judicial branch on court-ordered psychiatric evaluations and the intersection of that with insurance coverage, and on billing issues. So that's sort of a background. But --

So in October we decided -- we -- we got

to a point in our office where we were just seeing so much volume of cases coming in the door of mental health and substance use. And, again, what we see is so much broader than the kind of cases that the Insurance Department can even regulate because we see so many cases with employer-sponsored plans, and those are not regulated by the State of Connecticut. We just got to a point where what is going on? We really need to know what's going on in Connecticut.

So we -- we had a pretty long hearing. Many people were describing problems that obviously are problems that go beyond the scope of state regulation. But nonetheless, our -- our problems that are affecting residents of our state whether our state regulates them or not.

So we put out this report in January which I think is a pretty comprehensive report that talks about some of the issues around coverage issues with insurance- or employer-sponsored plans but also is much broader and goes to issues around capacity in Connecticut. And that means facility capacity, provider capacity. We go to cost-shifting issues, et cetera, which I'll talk about in a minute.

So just a little bit of background, and I think Anne Melissa's going to discuss this too. We have

a significant portion of our population, most of our population, two-thirds of it roughly, is covered by some kind of private plan, whether it's an employer-sponsored-plan, a federal plan, individual insurance that's regulated by the State or group, small group insurance that's regulated by the State.

We have a lot of people on Medicaid; we have about 700,000 people in Connecticut on Medicaid. We have about -- I think it's 13 percent or so, but I think our number is somewhere around there, 13 percent or so. And our current laws -- Federal law, as you may know, the Affordable Care Act in 2013 will prohibit plans from discriminating on the basis of preexisting conditions.

Right now and -- with respect to children, there can be no pre-existing condition, exclusion or prohibition or inability to get coverage. But for adults it's still a real issue. And mental health and substance use issues are -- people with those issues are impacted. Often people can't buy policies because they have a mental health or substance use condition, preexisting condition. Somebody may not want to write the policy because they think it's too much of a risk. So that's still an issue here.

In terms of background and coverage, for those who -- I know many of you probably already know

this, but for the public programs in Connecticut, for Husky, we have four different kinds of Husky here in Connecticut. We have a Husky A program which is Medicaid for families, essentially, children and their caretaker relatives. We have a program called Husky B which is a child insurance -- children's insurance health program. That also provides pretty comprehensive coverage for kids only and who are ineligible for Medicaid, so little bit higher income.

Husky C is the age, blind and disabled Medicaid population, many of whom need coverage for mental health and substance use services. And Husky D is the Medicaid low-income adult program. That is what we used to call the SAGA program; that rolled into Medicaid. And the services for Medicaid, mental health and substance use, behavioral health overall, are administered through the Connecticut Behavioral Health Partnership which I think many of you had probably had interactions with, the CTBHP. And DMHAS, the Department of Mental Health and Addiction Services, is also involved in administering some benefits for people in the Husky D program when they seek residential coverage, those low income adults.

And, as you may know, the benefits for those programs depend on the program you're enrolled in.

So Medicaid, federal Medicaid law is very comprehensive in the scope of services that people are required to receive if -- if it's medically necessary. So for kids up to the age of 21 there is a program called "Early Periodic Screening, Diagnostic and Treatment Services," EPSDT. That program essentially says for anything that Medicaid could cover in the universe, if it's medically necessary for that child, that child must get it.

It also requires that children under the age of 21 receive periodic mental health screenings. CHIP is a separate law but very similar. The benefits offered under CHIP are based on the largest employer plan in the state of Connecticut, so the benefits are slightly different than Medicaid, pretty comprehensive, though.

And then we have some people on our public programs, on the Charter Oak Health plan which is, I think by all rights, going to disappear when the exchange rolls out. But the benefits under that law are governed by state law. And then for the public programs there are other benefits, and here's a big -- this is a big key: There are lots of other benefits that are covered by our state agencies for people who are in public programs or eligible for public programs.

So services such as on this next line, I believe, community-based services that are offered by the

Department of Children and Families and by DMHAS. So for instance, emergency mobile psychiatric services, a very important service you heard people talking about that this morning as a really critical service. The State pays a hundred percent of the cost of those services. However, 33 percent of the kids who use that service are covered by a policy, some kind of health insurance policy. But the State is paying the full freight for that.

IICAPS, which is a really important program that DCF administers, Intensive In-Home Child and Adolescent Psychiatric Services, a program that has really been shown to prevent unnecessary hospitalizations for kids, is also a public program funded by DCF. However, some people with private insurance do access it because private companies don't -- we don't cover that in Connecticut. And then there's a couple other kinds of services that are community-based services that are provided by public programs.

And then, as you know, we have lots and lots of services that are provided through the courts, through schools, Department of Corrections. So I don't need to really -- I'm not going to really talk about this slide and -- because Melissa can do a better job than I can on it. And mental health parity is something --

where am I? Am I still -- Okay.

Mental health parity -- The Mental Health Parity and Addiction Equity Act is a pass -- is an act people often talk about the word "parity" and don't really understand it. And I don't think -- we haven't gotten to a final place, frankly, all of us of understanding it because the federal government has not issued a final regulation on how to implement the Mental Health Parity and Addiction Equity Act.

But essentially this is just some guidance about what it is. It passed 2008. The interim regulations -- the federal government passed interim regulations in 2010. But we're -- like I said, it's three years later and we're still waiting for the final regulation.

What it does not do importantly, the Mental Health Parity and Addiction Equity Act, is require these plans to offer mental health or substance use benefits. The -- The general way to think about this is if the plan offers the benefits, then they must comply with parity when they offer them.

Now, the state law requires that we offer some -- and I'm going to defer to Anne Melissa on that. But essentially this act and the regulation -- it's really in the regulation where the federal government

when it put out its regulation, it describes a couple times -- kinds of ways that there need to be parity in both state-regulated plans and employer-sponsored plans and individual plans, in 2014 individual plans.

Essentially what the parity law says if you -- this is a -- this is not straight from the law. This is a paraphrase. You can't really apply things -- apply your limitations more stringently on -- for mental health and substance use benefits than you do on the medical side. So you can't have financial limitations that are stricter -- this is a generalized way of saying it, stricter on the mental health and substance use side than you can on the medical side.

Now, our state law, also it has financial parity in it, but the interesting thing that the feds added and which is what we need more guidance on is this thing called nonquantitative treatment limitations which is kind of a fancy way of saying look, if you're going to have prior authorization for mental health and substance use services, you can't do it on a basis that's -- on a more stringent basis for mental health and substance use services than you do on the medical side unless you have some clinically appropriate reason to do so. And that's where the hang-up is in the law right now, is we really don't have that fleshed out.

But there are also things in here interesting that they -- the federal regulation talked about like you can't -- you can't have different reimbursement rate-setting methodologies for mental health and substance use than you do for medical. You can have different ones; you just can't apply them more stringently. The nonquantitative limitations apply to things like the way you set up your networks to formulary drugs, so it's a very broad set of limitations that the parity law would apply to.

Again, the problem is when you don't have a final regulation, it's really hard to implement things appropriately. So importantly, the ACA regs, the Affordable Care Act, regulations Obamacare makes the Mental Health Parity and Addiction Equity Act applicable to the new plans that we're going to sell in 2014 on the exchange. So the people who enroll in the exchange will get access or will be covered by this law.

However, the law does not apply to our Medicaid program, and that's because we don't have a Medicaid managed-care program in Connecticut anymore. And that's important to know because I think people think it does apply, but it does not.

We are operating, as I said, on interim regulations so to fill in the void, the feds have

developed a toolbox for employers to kind of assist them in helping them comply with mental health parity. And also this -- an entity called The Parity Implementation Coalition, they had asked Milliman -- which is an entity that maybe all of you are familiar with, they develop criteria, they're an actuarial consulting firm. But they also have a lot of involvement in mental health; they have their own guidelines. They're pretty comprehensive.

They developed a toolbox to help employers comply with the parity regulations while we wait for the final rule. So their stuff -- their guidance was really good because it -- for the first time somebody did an analysis to say well, you know what? Intensive outpatient is kind of equivalent to cardiovascular rehab. So the kind of limitations you're putting on cardiovascular rehab in terms of prior off and things like that, you can roughly try to compare those two things. It's a very difficult process right now without that final reg.

So that's all kind of background. So what are the facts as -- as we see them in our office? So this is directly from the Connecticut Hospital Association; it was part of the testimony that they gave us. I don't think it's going to surprise a lot of people around the table, but since 2008 we have seen a drastic

increase in the number of people going to E.D.'s for -- and E.D. nonadmissions. So what surprised me when I first saw this statistic was the number of seniors -- the increase in the rate of senior use of E.D.'s for nonadmission -- ED nonadmissions.

Children increasing by 48 percent and over all we have a 13 percent rate of increase in inpatient use at the hospitals. That is huge. For us at our office, what's -- what's happening in our office? Well, behavioral health is the number 1 clinical category. It's been the number 1 clinical category. It's still the number 1 clinical category, and I suspect it's going to remain the number 1 clinical category for a while.

The number of cases is as you seen -- has you seen -- as you see here, excuse me, have gone up by about three times in the last four years and are on a trend now to eclipse the 524 we got last year by quite a bit. And the primary issues we're seeing is, as you heard, I think, this morning, inpatient length of stay. So person is in for a day, two days, there's a denial and they're out. We've seen a lot of those cases where there's denials for there. Step-down program denials, so intensive outpatient, partial hospitalization, residential. The lack of instate capacity, that is

contributing to, I think, some of the problems.

So there may be intensive outpatients. Not everybody participates with the carriers or the carriers -- or not the carriers, but there just may not be enough of them, you know. And then what we see also is cost-shifting so this reference to DCF voluntary services, that refers to a project that OHA started with DCF just this past late summer. And that -- we started that project because DCF was looking at about $16 million a year that they were spending in DCF Voluntary Services which is a program primarily designed to help kids who really don't have access to other services get behavioral health services.

So there was a concern that there might have to be a cut to that program, but then we found out from them that there were a lot of people covered by health plans whether they're instate or federally regulated. So we said to them, well, why don't you let us try some of these cases and see if we can get them covered? And so far in only, you know, six -- six or seven months, we've recovered about 2.2 million meaning we've gotten coverage worth about 2.2 million paid for by a health plan for that person instead of DCF paying for it. Yes?

MS. FORRESTER: Vicki, I just want to

clarify just because I'm not sure everyone understands it, voluntary services, DCF offers some incredible wrap-around care, like IICAPS was one of the examples coming out of Yale. If you have a kid who's really incredibly disturbed and you want to keep him out of the hospital at a residential, you'd have the wrap-around.

Often Voluntary Services was used by folks who have private insurance because they need -- they couldn't buy that insurance through their private insurance. They would have to sort of get voluntarily hooked up with DCF to be able to access some of the high-quality services that folks who were receiving state services.

So I think it's -- coverage gets a little confusing, so that's -- that -- that's part of DCF, so you would call in and ask DCF or you would try to get your child admitted to Voluntary Services meaning that he had or she had high needs that you couldn't take care of on your own.

MS. ADRIENNE BENTMAN: This isn't a question, but I'm an adult psychiatrist, and it's actually difficult for me -- even me to understand what you're trying to tell us.

MS. VELTRI: Okay.

MS. BENTMAN: So I would imagine that

unless other members of the panel have had someone in their family or themselves have been ill, this is -- this is -- you and I live in an area that is very removed --

MS. VELTRI: You're right.

MS. BENTMAN: -- from anyone who hasn't had mental illness or the need for those services in their lives. So if you -- and we're on TV, so if you could speak to us as if we're clueless, it would really help.

MS. VELTRI: Okay. That's fine. Okay. So -- Okay. Let me skip to this observation slide because I think I can do that in this observation slide which is -- okay. So this might boil it down: So if you are a person in the state of Connecticut and you have healthcare coverage, you could have many types of coverage, right, so you could -- you're either uninsured, right? If you're uninsured, you're uninsured, you could have a public program meaning Medicaid, Medicare, TRICARE, something like that, or you could have private insurance through your employer or you could buy it yourself because you're not employed or for some other reason like that. So different ways of being covered, and the different ways of being covered, the law that applies to your particular situation will vary depending on the way you're covered.

So if you're covered by Medicaid, federal -- the federal law applies -- there's a comprehensive federal law that applies to Medicaid that is very robust, contains a lot of protections for consumers. If you're covered by -- you buy a plan on your own because you can't find insurance unless it's Charter Oak which is a state program that's run by the Department of Social Services, then that's in Anne Melissa's shop.

If you're covered by an employer, you could either have a plan that the state laws control or you could have a plan that the state laws don't control. So let me give you an example. So I work for a small business or I might be self-employed, chances are I'm buying a policy that's regulated by the State of Connecticut. If I work for a large employer, the State of Connecticut, UTC, GE, somebody like that, you have a plan that's regulated by the federal government, so the benefits that you get or the laws that apply vary based on your coverage.

However, what I will say is despite the variation in your coverage, at least from our perspective, when it comes to nonMedicaid coverage, nonpublic coverage, we see the same barriers across -- across -- across all kinds of health plans. So

whether -- from our perspective, whether you buy your own policy that the State regulates, a policy through your employer, you're going to run into in our view sometimes difficulties with getting your hospital stay extended or getting intensive outpatient services which is a step-down from a hospital or partial hospitalization which is another kind of step-down.

Our experience has been that -- a few things: There are different definitions that dictate whether something is medically necessary. So as a condition for getting your treatment or service covered under any kind of plan, whether it's Medicaid or a state-regulated plan or a federally regulated plan, you have to prove that it's medically necessary, that you need it basically. But the definition of what's medically necessary is different in state law than in the Medicaid program, let's say, for instance.

So the Medicaid program has a very broad definition of medical necessity, broader than it is for private insurance plans. So depending on what program you're in, you have different standard to meet to get your service. You may have also different benefits, and that happens all the time.

So under state law, there's --there is -- there is a statutory, a legal set of benefits that must

be provided under a plan that's regulated by the State of Connecticut. If you're -- If you work for UTC or GE or even the State of Connecticut, the employer basically designs the plan, so your benefits may not be the same as somebody else's. That's all important knowledge.

But the real issue is that when you get to your point of service, unless you're in one of the public programs -- and even the public programs are not perfect, but the private side is more difficult to maneuver for people. And what our -- what our perspective is -- so for instance, and I'll just give you a little bit of background. So the program review and investigations committee which is a committee of the legislature, it did its own study this past summer on adolescent substance use access to services under private insurance, and they expanded it to the public programs in the state of Connecticut.

And what they found is something that we -- we found ourselves which is that depending on the plan you're in, when you go, let's say and your doctor you call, right, for a service for one of your patients, I have to get a prior authorize meaning before -- depending on the kind of service, you got to get the carrier's approval if you want to get paid for that service. The carrier has to say it's medically

necessary, and if it's denied, you can appeal that.

But when the plans evaluate whether something is medically necessary, they have to use criteria. They have to develop criteria, and the criteria could vary between the health plans. And that -- PRI found that; we found that. So -- So depending on what plan you were in in Connecticut, you may have a better shot at getting coverage because the criteria might be more, for lack of a better phrase, consumer-friendly or -- or something in one plan than another plan. So you might have a better experience at one carrier than another carrier for the same service at the same hospital, so that was one thing.

We also found and PRI found that 72 hours is our current time frame for urgent appeals. So the time you file it and the time -- you file an appeal with your insurance company or on your initial request with your insurer whether it's instate or out of state, they have 72 hours to make a decision. That's too long. It's too long for mental health and substance use.

And I can tell you we've had a few cases with kids with mental health and substance use issues who went out of the hospital because they no longer met acute -- they didn't need to be in the hospital anymore, but they needed the next program, and they had to wait

three days. Because they had to wait three days, they started using, and they ended up back in the hospital.

So that -- that's the kind of thing we'd see with that 72-hour turnaround, too long, too long. And another view we have -- and I will say we -- we are working on this right now, and we're actually working with the carriers very well right now, going to try to resolve some of these issues. But things like so if I ask for an extended hospital stay, we have a child in IOL or somewhere and they need another couple days and the IOL puts into whatever carrier it is, the review does not have to be done by necessarily someone with the same background.

So what we are seeing is maybe it could be a nurse, and I have nothing against nurses; my sister's a nurse. But you may not have the psychiatric training or something to evaluate whether or not that child needs the service, yet that's legal right now. And we feel strongly that you need to have the right peer reviewing somebody's case. So just like a general surgeon, I know -- I wouldn't want a general surgeon or my brother, who's an orthopedic surgeon, reviewing a cardiologist's opinion. I don't want a provider who's not a mental health professional reviewing somebody's mental health application for services. So that's

another issue that we see.

So those are kind of like the broad plan issues that we're seeing. And as a result, we're seeing, I think, more denials than we need to. However, like I said again, we are having very good conversations right now -- right now with the carriers around these issue, and I think we're going to come to some agreement on that.

But in general some of the other issues we're seeing -- and the reason it's important and I wanted to come and be with Anne Melissa is because the issue is not just insurance. It's so much broader than insurance. You know, the models are different. Our public model is a completely different model from the insurance model, right? So insurance is you go for a service and you're getting reimbursed, right? That's -- That's the model right now.

We're moving in a lot of ways towards other models like patient-centered medical homes and accountable care organizations to try to make care more integrated. But right now essentially that's the model for insurance. For Medicaid recipients, for people on Husky, slightly different model. There's an ASO arrangement with value options, so Administrative Services Organization which you really don't need to know

probably.

But the behavioral health partnership tries very hard to integrate care with the primary care side of things. And there are people reviewing requests for care who match the kind of provider who asks for the service generally speaking a more integrated kind of healthcare system, I think. That's at least my view of it. That's one issue.

We have work force issues. We really seriously have work force issues here. Somebody asked about the child psychiatrist situation. There's 8,000 child psychiatrists in the United States, 8,000 for how many mill -- 300-something million people in the United States. The safety net is really bursting at the seams. And we have 77 percent of the people who go to FQACs are covered by private insurance. And the community providers, I think you probably have heard -- I don't know if you actually have -- the nonprofit providers provide so many services, the child guidance clinics, they provide tremendous services, but they too are overwhelmed.

So there are a lot of issues around barriers to access to mental health and substance use treatment in Connecticut that get to go way beyond insurance. In fact, DMHAS itself, DMHAS has a really

good model called a recovery model. That's a model that says, look, we know when you have an issue around mental health and substance use, it isn't always just about that particular issue. There's usually something else going on, whether it's another medical issue or a housing issue or a job issue.

So DMHAS has a recovery model where they -- they -- they look at the person as a whole person and their life experience. So they provide services like housing supports and things to help people -- to help people recover essentially. So those are most of the barriers we're seeing.

Some other kind of things I think you should know about, that people should know about are this -- these cost-shifting issues. You know, just the DCF experience, why is the State paying for something the State shouldn't be paying for? That's -- That's something in our watchdog hat that I kind of feel strongly about, that the State shouldn't be paying for things it shouldn't have to pay for.

Why is, you know, emergency mobile psych, 33 percent of the people using it are covered by insurance, why is the State picking up the whole tab? So the point there being, there's cost-shifting going on, but really what are we doing with the resources we have?

You know, if the State isn't picking up that cost, maybe somebody else who needs that service could get it, you know? There's -- There's reasons you want to be cognizant of the cost-shifting. And right now we're really not looking at it. I don't think the State really has a good estimate on the amount of cost-shifting that's going on. It really does need to be studied.

So I see some other few things. There's a -- our experience has been that there are limited options for outpatient. And for the few cases where kids do need residential, you can't get it in Connecticut unless you're in a DCF arrangement, and DCF has some residential treatment centers. There's not a lot of gathering of data at the point of enrollment for demographic information, that's race -- ethnicity, excuse me, language preference, things like that so we could track health disparities for people coming into the systems.

If you heard this morning, prevention and intervention, I think, are very underfunded, and we need to do something about that. And, frankly, the State, we could not find -- when I was doing this report, I could not find a single study on the cost effectiveness of our current programs. And to me, that feels like a necessary task. Especially in a tight budget, you really want to

make sure everything is working as it should and that everything is as efficient as it can be so we can help people who really need help.

Frankly, these -- I mean, the last few slides are our recommendations, so if you read the report, you saw them mostly around integrating, having an overall vision of health that integrates mental health and substance use prevention and treatment into overall health instead or its own discrete thing, its own discrete topic, promoting prevention, early intervention, resources for schools, school-based health centers, strengthening the mental health screening requirements in the Medicaid program, helping providers train and do mental health screenings, evaluating cost-shifting and really allowing people who are in plans that don't offer these services to get access to them in some way and figure out a way to make those really highly successful evidence-based programs that exist in the community available to everyone in Connecticut, everyone.

So that's pretty much a summary of a lot of slides, I realize. But we could be here all day talking about this so -- so with that, I know Anne Melissa, I've been keeping her sitting over here, so she's probably -- chime in, but I don't know if people have any questions or if you want to wait till Anne

Melissa's done?

MR. JACKSON: We want to hear from insurance person and then ask integrative questions. Why don't we do that? Dr. Schwartz?

DR. HAROLD SCHWARTZ: I'd like to ask a question of Ms. Veltri before we start. First of all, thank you for coming today.

MS. VELTRI: You're welcome.

DR. SCHWARTZ: But also thank you for the report that you -- you issued earlier in the year which I think was a landmark in terms of establishing many of the problems that we have in our -- in our current system which I put in quotes of care.

MS. VELTRI: Thank you.

DR. SCHWARTZ: It is ironic to me to think that the individuals seeking care within the public sector in Connecticut have a more organized, systematic and kind of reliable system for obtaining care than anyone who is seeking care in -- through commercial insurance. And while I agree with you the problem is much larger than insurance, for those who are commercially insured, insurance is a big problem.

MS. VELTRI: Yeah, it's an issue, I will say.

DR. SCHWARTZ: It's a mental health

issue, in fact.

MS. VELTRI: Yes.

DR. SCHWARTZ: So the nonquantitative treatment limitations, medical necessity, I think, you know is clearly the largest issue. Medical necessity drives prior authorization, it drives then denials of care for ongoing care. An -- My observation is that medical necessity for psychiatry is scrutinized and determinations are made in a way that is not seen in any other area of medicine. So your observation or your -- your comment that cardiovascular rehabilitation may be similar to IOP, I have a series of questions about this. Have you ever tracked or compared the number of denials, either prior authorization denials for cardiac rehabilitation as opposed to denials for intensive outpatient care?

MS. VELTRI: I have not. We have -- There is that data available.

MS. DOWLING: I'll get to that.

MS. VELTRI: Yeah, okay.

DR. SCHWARTZ: Okay. I want to make a prediction.

MS. VELTRI: There is state data.

DR. SCHWARTZ: When get to that data, there will be very few denials --

MS. VELTRI: Yeah, I know.

DR. SCHWARTZ: -- for cardiovascular rehabilitation. And, Melissa, you may prove me wrong, but --

MS. DOWLING: No, I won't.

DR. SCHWARTZ: -- very few. I would guess 1 to a 100, maybe 1 to more than that compared to IOP. I'm convinced after a lengthy career in psychiatry and dealing with the parity issue for -- for most of those years that the central issue is the issue of definition of medical necessity. But actually it's not the definition.

MS. VELTRI: It's the application.

DR. SCHWARTZ: It's the implementation. It's the application which is entirely a soft judgment by the person on the other end of the phone who's making that determination. And depending on the company that that person works for, the results will be tremendously different. And my guess is that you have the data --

MS. VELTRI: Yeah.

DR. SCHWARTZ: -- that demonstrates that in Connecticut if have insurer A, your chances of being denied for the same hospitalization are a hundred percent or 200 percent greater --

MS. VELTRI: We do.

DR. SCHWARTZ: -- than if you have insurer B.

MS. VELTRI: We do.

DR. SCHWARTZ: Great. So one question is what can we do about that? We have the data. And yet -- and yet --

MS. VELTRI: I know.

DR. SCHWARTZ: -- the problem goes on year after year after year. It's compounded by the fact that denials of prior authorization, not denials of ongoing care, but of prior authorization must be appealed by the patient. It's the provider who's stuck providing the care. I assure you, at the Institute of Living we do not send people out to the street who need hospitalization because we do not get prior authorization.

MS. VELTRI: Right.

DR. SCHWARTZ: We hospitalize them --

MS. VELTRI: Right.

DR. SCHWARTZ: -- and we provide treatment. Then the patient has to go out and -- We -- We're capable of taking on the denial when it's a denial of ongoing care. We do it all the time, and we win a fair -- pretty fair amount of them. But we can't do anything about the denial of prior authorization. And

yet we must morally and ethically, you know, provide that care. So question 1. I have a second question is what can we do about this? I'll hold off on my second question because until I hear the answer to the first.

MS. VELTRI: Well, I have maybe part of an answer to the second question, and I'm sure Anne Melissa has the other part or a big part of an answer to the second question. So the first question, I will say in the PRI report, PRI pretty much substantiated what you just said. So depending on the carrier you are in, there were statistically significant differences in approval rates depending on the carrier for different levels of services, so if you want to see that, that's on the PRI Web site which is available through the General Assembly. So that --

DR. SCHWARTZ: I'm sorry, PRI stands for?

MS. VELTRI: PRI is Program Review and Investigations Committee, so it's at CGA.ct.gov, slash, PRI. So they -- they did show that, so that was clear. And part of what we can do about it -- part of what I think we can do about it is to make our statutes tighter around the kind of criteria that can be used so the criteria doesn't vary between carriers so much anymore which it does right now; it varies quite greatly between carrier. Make sure the clinical peers are the right

clinical peers. Those are two things I think we can do in statutes right away and insure that -- again, that the turn-around times are much quicker so we're not ending up with free hospitalizations which is something we do often see.

DR. SCHWARTZ: Are any of the bills before the legislature in this session --

MS. VELTRI: Yes.

DR. SCHWARTZ: -- adequately addressing these questions in your view?

MS. VELTRI: I think so, yes. Partially. They won't -- I don't think any of our bills will completely address them. But I do think they go a significant -- significant way towards addressing some of them and -- but, however, I will say we can't touch, again, those 60 percent of people who are in those federal plans; we have no power over them. The federal government does, though. So that -- that's a partial answer to the second question, and I'll let Anne Melissa --

DR. SCHWARTZ: We got confused on first or second questions. I had another second question that I haven't asked yet.

MS. VELTRI: Oh, okay, I'm sorry.

DR. SCHWARTZ: Okay, just a question to

change the subject for a moment. This is about child and adolescent access, beds, Emergency Department experiences. Your report addressed this issue. I was very pleased to see that, and I thought you addressed it in, you know, an emphatic way. So you know that we have a crisis in --

MS. VELTRI: Yes.

DR. SCHWARTZ: -- adolescent -- child and adolescent psychiatry. And the fact that, by the way -- and I want to say to everybody, the fact that I'm emphasizing the hospital end of this, the Emergency Department and inpatient beds, does not for a minute suggest that I believe that, you know, this is the central issue.

MS. VELTRI: Right, right.

DR. SCHWARTZ: You know, the whole entire continuum of care out into the entire recovery movement is an important issue for this commission to be addressing. I happen to live in -- in the inpatient world, however, and am very familiar and concerned with these issues, so I -- I focus on them. So there are days when of the 26 beds in the Emergency Department at the Connecticut Children's Medical Center, which is a full-service Emergency Department, more than half of those beds are filled with children and adolescents who

are there for behavioral health problems. There are days when that's true and there are no beds in the crisis unit at the Institute of Living and no beds on our child and adolescent unit and no beds --

MS. VELTRI: Anywhere.

DR. SCHWARTZ: -- anywhere in the state of Connecticut.

MS. VELTRI: That's true.

DR. SCHWARTZ: The problem is increasing. It's just growing day after day, week after week, month after month. At the same time, Division of Children and Family Services is decreasing the congregate services and has eliminated adolescent beds at the Riverview, slash, Solnit Hospital. I hesitate just to call it Solnit. People won't recognize it if I call it just Riverview. It kind of won't be contemporary, but -- so you know, I see a paradox here. And I see agencies not fully working with providers and not necessarily working with each other. What are your recommendations for moving forward in the crisis we have right now, today?

MS. VELTRI: Well, I -- I agree actually on that last point. That is why one of the recommendations is having somebody coordinate the system. There are so many agencies that touch mental health and substance use. You got DCS, DMHAS, DSS, judicial,

Corrections, on and on who touch it in one way or another. But it's not really coming -- you know, it's not really coordinated across the systems. So I strongly feel like we have to use our authority in our statute to convene people around it. Actually, the Child Advocate Jamey Bell and I have been working really hard on this issue to get people to focus specifically on the ED issue.

We actually met with CCMC and the hospitals around this, the ED back-up, about a month ago. And there's several what seemed to be contributing factors, only part of which I think is related to denials and people getting readmitted -- or coming back to the E.D.'s for services. The providers in the room were suggesting that much of it is acuity is increasing, the acuity is increasing out there, and the economic circumstances in our state have led to more people experiencing mental health and substance use issues and families now coming to hospitals together contributing to the back-up.

So it is much more far-reaching than just obviously the insurance issue. But our -- our commitment was that we would work across agencies and across provider groups and consumer groups which I think also need to be involved in the discussion to attack

specifically that problem and -- and more broadly this issue of coordination which I frankly think if we don't have a coordinating entity around mental health and substance use across the state, we'll continue to just see the silos, and we can't do that, we just cannot do that anymore, can't do it. I don't know if that really answered your question, to be honest.

DR. SCHWARTZ: I would be surprised if you could fully answer my question.

MS. VELTRI: Yeah.

DR. SCHWARTZ: I agree that acuity is part of the problem. Depression rates are rising internationally. Suicide rates are rising dramatically internationally. But I would add that there's another factor, and that is the disincentive to expanding care because certainly what winds up in -- in our child and adolescent E.D.'s are problems that started out on a smaller basis the week before or two weeks before or three weeks before.

MS. VELTRI: Well, yeah, that really goes back to me to some of the community-based service options, so it -- that's part of it. If lots of these hospitalizations, I mean, the data from IICaps is pretty substantial and pretty convincing that the intervention keeps kids from going to the E.D. and -- but it's only

available to a small group of kids. And if it's -- so those kinds of services have to be available to everyone.

But in addition -- so we need to make sure they're used effectively but also that it is available to the wider community as a whole. And we also need to, I think, decide -- if our theory is that people will do better in the community, then we have to have services. We -- We can't just say we're going to close facilities and not have services in place in the community for people to get them. And that has been a problem; I mean, that's a problem -- even if you're insured, that's a problem because if we don't have facilities anymore, people or even IOP programs or intensive outpatient to go to to avert a hospitalization.

So we have a significant number of problems, I think, which go -- cut across every agency, every service area, every income bracket, every geographic area of the state, and they all need to be brought together in one place to be addressed. And it needs to -- it needs to be a cohesive strategy to get at it because they're just too much to try to do addressing the insurance issue without addressing, community-based services or acuity or --

There's just a whole slew of issues that I think need to be more comprehensively addressed. And I

think the important point is from my experience is, this is going to take some time. We're not going to fix this system in three months. So I mean, I think there's some discrete things we can do around prevention, frankly. Public awareness campaign would be a good thing in my opinion to try to attack some of the stigma issues that we have. But that is not going to change the entire system overnight. We have a lot of work to do, and it's going to take time. That's my sobering answer. I'm sorry about that.

DR. SCHWARTZ: My colleague asks who's going to do that?

MS. VELTRI: Well --

MR. JACKSON: Well, we talked about through statutes convening such an opportunity. So why don't we add insurance to the mix? These items are interrelated.

MS. DOWLING: Let me slide over there. Oh, okay. I didn't mean to abandon you, but I was in the blue light there. On behalf of the Department of Insurance, I first want to say we're just grateful to be invited to the conversation, so thank you for that. And personally I'm very humbled by the work you're all taking on on all of our behalfs, so thank you. The one thing we can bring to the table is the regulatory authority, and

so we put that at your disposal. So what I want to do briefly this afternoon is just tell you what are the tools you have with your insurance department to work with and what you don't have, what we don't have authority over. It will actually go a little bit faster than I'd intended because Vicki's covered some of it, and that will be good. No, no, that's fine.

Some of the results of, you know, our oversight when we find violation of law is financial, fining. Sometimes it's a few thousand dollars; sometimes it's a few million. And most severely there could be license revocation. But we don't necessarily find that to be effective because the people who could get hurt are the ones that need things the most, the -- those who are covered, the employees, you know, the economy of the state, all of that. So we usually have other means. Sometimes it's the suspension of a sale of a particular product, all of that. But this conversation, I just want to state, will probably feel somewhat it's very financial.

So I just want to say that. So let me talk for a few moments, just behind me I'll just show you, you know, what we do. We've been around for, you know, about a hundred forty-one years from statute with the mission to protect the consumer of the state of

Connecticut. So you can see just down below what -- how we sort of define that.

I'm going to talk to you about the things that impact this particular topic, but the department is -- I even found after having been a consumer of it being on the for-profit side for my entire career, when I came onto this role didn't realize how incredibly broad and deep the department's tool set is and staff is and some of the things we won't talk about today, and we have to remember that there's a very large part of the department that's sole focus is to make sure that the companies stay solvent and -- so that they can maintain their promises to their policy owners.

So we have regulatory authority over individual and group commercially insured products. We do not, as Vicki said, have it over self-funded plans which are regulated by the Department of Labor. But I do want to even go specifically there. So she's described what a self-funded plan is. We all participate in one as State of Connecticut employees.

But even more specific, the Department of Labor -- this falls under an ERISA law. You probably see here this occasionally maybe with your retirement plans or things like that. But it actually regulates the employer that offers it. So to be really specific, they

go in at the employer level and talk about it. So we -- we can talk about and regulate the financial machinations of somebody hired as a third-party administrator. So let's say the State of Connecticut, let's just say, or a large company would hire an insurance company's nonregulated side of the business but, in fact, it's what's called Administrative Services Only. You'll hear the term ASO.

They will regulate the claims paid -- I mean, they will administer the claims paying, move the money around, you know, do the claims review, all of that. But in -- they're called -- the people who do that sometimes on a private level for smaller groups are third-party administrators. We can regulate the moving of the money, making sure they're keeping their contractual promises. But in that case, we don't go through to plan design or benefits.

So you know, again, that's -- whenever insurance is raised, we get a lot of inquiries into the department, and unfortunately our statutory authority is fairly narrow. And then the other plans you've heard about you can see below it. So similar numbers, so I won't stay on this, but just, you know, to crystallize it a little bit, fully insureds, you know, a little less than a third, self-insured maybe a little bit more than a

third of those out there in our state, and then the other programs up here. So we're roughly -- these numbers are dynamic, obviously; people go in and out of different programs. But just so you can size what we're dealing with and what we can help you with in terms of our oversight and what we can't.

There is a Life and Health Division. So think of this when a carrier is putting together a product, it needs to come through the department to have its policy, its form and any product design approved by the Department before it can, in fact, offer it. And then we need to make sure while reviewing it that these policies meet all the state and federal laws that are out there including mental health parity compliance.

But that's going to be at a very large, fairly broad level of definition. And then, of course, you read about us all the time in the news of the work we do in terms of reviewing the actual rate actions, you know, the rate at which your premium goes up or down each year.

So one of the very important units in the department is our Consumer Affairs Department. It's composed of 15 people, and anybody who's fully -- a policy owner in a fully-owned -- a fully -- a private fully-insured plan is protected under that authority. So

that unit receives, reviews and investigates any consumer complaints and inquiries, again, just for the commercial insurance side of things. When we get things that fall outside of that, we refer it to Vicki. Right now she's down the hall from us; when you move, that's not going to be so great, but we will get that done.

There's a lot of very deep subject matter expertise there, and this is not only healthcare but, you know, overlapping things like homeowners, auto, all of that. So if you're dealing with a shoreline issue or some of the damage form the storms, they're on there. But they specialize.

One of the things I think that's not understood is that there's a -- they spend their days helping individual consumers navigate the claims process as well. So they take personally a lot of these claims that come in and work -- walk through with an individual as to how to navigate that process. Doesn't mean that because we get involved, a claim denial's going to be overturned. It means we will do everything we can to find the facts. And, you know, many a time we have to turn around and say no, your policy is limited this way, unfortunately, and it's not going to change.

They do assist in appealing the denials to the carrier for the review process. And I don't want

to -- at the advice I heard from you go too far on this, but if you're in a healthcare plan right now, you have several layers of what's called an internal review, so the company needs take you through, and we help take the care -- the policy owner through an internal review. They control; they hire the people, all of that.

If that still fails, you have the ability to avail yourself of an independent external reviewer. Those, then, we -- when a policy owner wants to avail him or herself of that, come to the department and we on a rotating basis assign an independent review organization to do this work. And we don't do the review; we assign it to them. And then they go through.

Finally -- And so this is more of the work, and I'll talk to you about some of the results of that in a moment. What the Consumer Affairs Unit does in addition to a lot of outreach in the state in terms of helping people understand the commercial policies they have, what they do have, what they don't have. You saw us a lot during the storms. There's a lot of work we do on healthcare, getting people ready for 2014, how it's going to impact an individual, how it's going to impact you as a small business owner, what kind of rate surprises or, you know, up and downs, how you might fit there. You know, people just need to plan, what kind of

business changes, business model changes they will have to deal with based on who is in the business.

The external review program that I referred to a minute ago, these are generally disputes related to medical necessity, not necessarily policy coverage or not; that's fairly straightforward. And I think I've mentioned most of this. You know, they're unaffiliated with the companies, and they must assign a reviewer who is a clinical peer. At this level clinical peers are well defined.

And if it's found that, in fact, this coverage should be, in fact, financed, then -- and the consumer wins, then the carrier must pay right away. Right now at this level -- now, mind you, this is four layers up -- of review, 30 to 40 percent of the denials are -- are overturned.

So just -- again, just wanted to set the table before we get to some of our observations and suggestions of what your department has for you to avail. So let's say that as a result of -- and we do this every year. Depending on what we see as themes coming out of the Consumer Affairs Unit, right next door to them is the Market Conduct and Fraud Unit, and they see the themes that come up every year.

So just like the Office of the Healthcare

Advocate, we are starting to see themes now in behavioral health and mental health denials, a lot of things that are out there that the system is working. In fact, you know, our Consumer Affairs Unit is compiling themes and trends, and this is what we're seeing as well.

So to your question, one of the things by statute we're required to do is survey our carriers every year, get all kinds of data from them, and we put out a report card. We'll be getting our data again this year -- I think it's May 1st or whenever the data is due to us. And one of the things we have been looking at here is utilization review statistics and specifically in here is for -- you know, we'll look at things like inpatient mental health, inpatient substance abuse, outpatient, outpatient substance abuse treatment, and then we list the carriers over the top and we show their numbers.

One of the things that PRI -- the report that Vicki referenced in reviewing some of the suggested to us that we make even more data available here, do some of the summary data, show the percentages rather than just the raw data, so we're going to be improving this as well. So we're already statutorily required to prepare a report, and it's very visible out there because it's by -- and it -- all kind of things in here. But, yes,

there is behavioral health as well. And it's, you know, carrier by carrier, so there's no hiding.

That doesn't mean that just because we see it, it's changed. But there -- you know, fortunately, there is this year our focus -- we do reviews routinely anyway of companies and go in not only on a financial side but on a market conduct perspective. And this year the focus -- we're already under way with a couple of them.

Again, by practice, we don't talk about them until they're done because it's not fair to say we're going in looking at you -- this because we're hearing this and we're seeing this. If, in fact, we find nothing, you know, it's somewhat libelous or whatever, so we're -- But as soon as we are done, everything we have found and everything we've communicated -- fines, changes of practices -- now is public information.

So we're starting -- we've started a couple already with some of the largest carriers on behavioral health and some -- based on the information we see here, based on prompting from Vicki's area as well, again, only within the area that -- that we regulate.

So I see the system as working, but the frustrating thing is the way the process works, we're looking backwards. So we can only sanction, require

changes going forward, not only fine but remediation if possible, all that type of things, so that's what we are in the middle of doing.

So far the department in this type of work over the last three years or so has returned about $22 million to the State. I'd say about 12 of that went back to the policy owners for inappropriate or payment that didn't happen that should have, and another 10 in fines. And that goes to the General Fund of the State. So again, everything we do there is -- is public.

So let's start getting to kind of the thing you really want to talk about, but I just wanted to give you a little frame work. In enforcing mental health parity, we've got a couple of challenges. And, again, Vicki has mentioned some of this. It's very clear how to do this financially, you know, number of limits, equal co-pays, all that type of thing; that we can see; that we understand, visit limits, that type of thing. And I'm not going to repeat this; Vicki has pretty much told you what is mental health parity, you know, how's it defined, all that.

But some of the challenges we have -- and you've reached -- you've mentioned this too -- you can't see it. It's not like you can do an x-ray or an EKG or something and see the issue. So the clarity is missing

in the innermost, particularly in the nonquantitative stuff. And, further, you know, how do we -- because we're really looking at this from a financial point of view; we do not have the authority to go deep down in and question a carrier's medical protocols. We can review them -- and I'll talk to you about that in a minute -- with an external medical source. And I'll talk to you about that in a second.

But there is a phrase in the federal regulations that says "require comparable services except when clinically appropriate standards permit differences," and these are not defined. So we can -- we're not sure what to do with that. So one of the things you were asking is, you know, is there legislation and all that? The only thing we can suggest is convening a group of professional practitioners, doctors, you know, the full spectrum, as you were saying, to help us maybe further clarify, at least on a state level, what these look like because right now there's somewhat judgment, carrier-determined, different and all that type of thing. And there's nothing for a financial agency necessarily to use to work with. And it is probably not in our wheelhouse anyway; that's not the expertise -- we don't have medical expertise in the department. So that's one thing we might suggest.

Couple of these points I think I've -- I've already made to you. There are some things I'd like to talk to you about, but I want to get through the presentation. You know, the preauthorization, there are some possible unintended consequences of changing the time for that.

But let me -- let me leave that for the moment and say, one of the things we do have at our disposal is a contract with the University of Connecticut Health Center on questions of medical necessity denials. If we see enough of a trend or even a request coming in, you can see up on the slide, you know, 11 times since 2008 we've, in fact, gone in and said we need to review this.

So for example, we saw a trend of a particular type of treatment being denied because it was experimental. Well, the last time it was defined as experimental was several years back; it had now become mainstream, and so we needed to have an outside medical authority help us redefine that and say no, you now need to start paying this because, in fact, it is mainstream. I mean, I'm trying to make this in very simple terms, so I apologize if I'm oversimplifying it, sort of making it a little cruder.

But -- And then also each year or most

years we are asked to then go review anything that's legislated as a state mandate so that an insurance policy has to pay for X service now, it's required by law, it's not a choice. And so we tend to ask UConn under its contract with us to look at that, help us to find the cost of it to the State, all of that.

And we have most recently used them just this year to help us review a carrier's mental health protocols -- that again something that we're in the middle of, when that's completed will be public knowledge. But I need to assure you that one of the things that frustrates our agency is we do a lot, but there's a time lag before you get to see it. So it's -- it's under way. We just, you know, by practice need to protect them until they're -- until it's all complete.

So here's something -- you know, Vicki's mentioned some very large, broad issues. From our agency's, you know, scope, there's only a few things that -- a few observations we've made, a few things we're going to try to do. We can come to the table on a lot of things, but so far we can only operate within the laws that, you know, we have authority over. So while we may have very similar opinions and thoughts and perspectives, you know, we're limited by, you know, what -- what our tools are.

So one of the things we see is an enormous trend -- and I'm not quite sure how to do -- handle this or -- and I -- so we can talk through some of this because earlier today you heard, you know, on the provider side about reimbursements being so minuscule based on -- relative to the charges. We see an awful lot of the challenges that come out of because most -- many of our complaints come -- in -- in the behavioral health area come because the providers are out of network for all good reasons: They don't want to be part of the system; they -- you know, they want to be paid fully. You know, whatever the reasons are, there's no value judgment there, but what it says is is that the client, the patient has to pay up-front and then be left with all the points you were making --

[End of DVD.]

CERTIFICATION

I hereby certify that the foregoing 82 pages are a complete and accurate transcription to the best of my ability of the electronic sound recording of the March 22, 2013, Sandy Hook Advisory Commission hearing.

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Aimée M. Suhie, RPR

Notary Public

State of Connecticut
LSR No. 00022

My Commission Expires:
May 31, 2014