

Legislative History for Connecticut Act

PA 14-58

HB5373

House	1526-1534	9
Senate	2920-2923	4
Program Review	60-64, 84-86, (87-93), 94-100, 133-134, 135-136, 150-156, 209, 211-214, 215, 216, 223, 225-229, 230, 232-241	54

H - 1185

**CONNECTICUT
GENERAL ASSEMBLY
HOUSE**

**PROCEEDINGS
2014**

**VOL.57
PART 5
1361 - 1680**

pat/gbr
HOUSE OF REPRESENTATIVES

17
April 22, 2014

Total number voting	143
Necessary for passage	72
Those voting Yea	143
Those voting Nay	0
Those absent and not voting	7

SPEAKER SHARKEY:

The bill as amended passes.

Will the Clerk please call Calendar 135.

THE CLERK:

Calendar 135 on Page 44 of today's Calendar,
Favorable Report of the Joint Standing Committee on
Insurance and Real Estate, Substitute for House Bill
5373 AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS
COMMITTEE CONCERNING THE REPORTING OF CERTAIN DATA BY
MANAGED CARE ORGANIZATIONS AND HEALTH INSURANCE
COMPANIES TO THE INSURANCE DEPARTMENT.

SPEAKER SHARKEY:

Representative Mushinsky.

REP. MUSHINSKY (85th):

Thank you, Mr. Speaker. I move acceptance of the
Joint Committee's Favorable Report and passage of the
bill.

SPEAKER SHARKEY:

pat/gbr
HOUSE OF REPRESENTATIVES

18
April 22, 2014

The question before the Chamber is acceptance of the Joint Committee's Favorable Report and passage of the bill. Will you remark, madam?

REP. MUSHINSKY (85th):

Thank you, Mr. Speaker. The Clerk has an amendment, LCO 3817. If the Clerk could please call and may I be allowed to summarize.

SPEAKER SHARKEY:

Will the Clerk please call LCO 3817, which will be designated House Amendment "A".

THE CLERK:

House Amendment "A", LCO 3817, introduced by Representative Mushinsky.

SPEAKER SHARKEY:

The Chairwoman has sought leave of the Chamber to summarize. Is there objection? Seeing none, you may proceed with summarization, madam.

REP. MUSHINSKY (85th):

Thank you, Mr. Speaker. This Amendment does two things. It first delays the reporting date to get at least one year's data from the federal All Payer Claims Database and use this data, if possible, to satisfy the requirements of the bill.

And second, it has the Connecticut Health

Insurance Exchange Board of Directors report to the PRI Committee on the progress made to provide the data on provision of children's mental health.

We are especially interested in this data because of testimony from the families that they were having a continuing problem to get treatment for their son or daughter. This is the mate to the bill we previously passed, and I move adoption of the Amendment.

SPEAKER SHARKEY:

Thank you, madam. The question before the Chamber is adoption of House Amendment "A". Do you care to remark? Representative Carpino.

REP. CARPINO (32nd):

Thank you, Mr. Speaker. A few questions, through you, to the proponent of the Amendment.

SPEAKER SHARKEY:

Please proceed, madam.

REP. CARPINO (32nd):

If the proponent can please explain why the reports from the Health Insurance Board will be made quarterly? Through you, Mr. Speaker.

SPEAKER SHARKEY:

Representative Mushinsky.

REP. MUSHINSKY (85th):

pat/gbr
HOUSE OF REPRESENTATIVES

20
April 22, 2014

Mr. Speaker, I cannot hear the question.

SPEAKER SHARKEY:

We're debating an Amendment right now and the proponent is trying to field some questions from Representative Carpino. If you could take your conversations outside the Chamber, and otherwise quiet the noise level down in the Chamber we'd appreciate it.

Representative Carpino, would you mind repeating your question?

REP. CARPINO (32nd):

Not at all, Mr. Speaker, thank you. If the good proponent could please explain why the Connecticut Health Insurance Board will be making these reports quarterly? Through you.

SPEAKER SHARKEY:

Representative Mushinsky.

REP. MUSHINSKY (85th):

Through you, Mr. Speaker, we are hoping to rely on the All Payer Claims Database and it has some information that we need, but we also need to know whether claims were denied as well as claim that were served. So that is the reason for the quarterly payments.

pat/gbr
HOUSE OF REPRESENTATIVES

21
April 22, 2014

It will give us a handle on whether parents are getting care for their children and their adolescents because claims will be, claims denied will be included in the quarterly reports.

Through you, Mr. Speaker.

SPEAKER SHARKEY:

Representative Carpino.

REP. CARPINO (32nd):

Thank you, Mr. Speaker. And if the proponent can please explain to those unfamiliar, what the All Payer Claims Database is? Through you, Mr. Speaker.

SPEAKER SHARKEY:

Representative Mushinsky.

REP. MUSHINSKY (85th):

Through you, Mr. Speaker, this is the new federal database and we were asked by the insurers out in the hall to amend our bill slightly to allow a one-year data from the new database, which is required in federal law and to see if we could use this to satisfy the requirements of the PRI report.

We should have a better handle on this after a year's worth of data and we will, we agree with the insurers that it makes sense to try to use the federal data first. If there is anything missing in there that

pat/gbr
HOUSE OF REPRESENTATIVES

22
April 22, 2014

we need, we can then supplement it later.

Through you, Mr. Speaker.

SPEAKER SHARKEY:

Representative Carpino.

REP. CARPINO (32nd):

Thank you, Mr. Speaker. And finally, could the good proponent please explain if these reports would impact HIPAA or confidentiality of the patients?

Through you.

SPEAKER SHARKEY:

Representative Mushinsky.

REP. MUSHINSKY (85th):

Through you, Mr. Speaker. There's no change in the confidentiality and no change in the FOI law.

SPEAKER SHARKEY:

Representative Carpino.

REP. CARPINO (32nd):

I thank the good lady for her questions, and I urge adoption of this Amendment.

SPEAKER SHARKEY:

Thank you, madam. Would you care to remark?
Would you care to remark further on House Amendment "A"?

If not, let me try your minds. All those in

pat/gbr
HOUSE OF REPRESENTATIVES

23
April 22, 2014

favor of House Amendment "A" please signify by saying
aye.

REPRESENTATIVES:

Aye.

SPEAKER SHARKEY:

Those opposed, nay? The ayes have it. The
Amendment is adopted. Would you care to remark
further on the bill as amended?

REP. MUSHINSKY (85th):

Mr. Speaker.

SPEAKER SHARKEY:

Representative Mushinsky.

REP. MUSHINSKY (85th):

I'd like to thank the members of the PRI
Committee and the staff and my Ranking Member and
Senator Markley for bringing this issue to the PRI
Committee's attention, and also to the Coalition for a
Better Wallingford, who has been working tirelessly to
get help for adolescents in need of substance abuse
and mental health treatment.

I urge your support for this bill.

SPEAKER SHARKEY:

Thank you, madam. Do you care to remark? Do you
care to remark further on the bill as amended?

Representative Carpino.

REP. CARPINO (32nd):

Thank you, Mr. Speaker. I urge adoption and support of this bill. Again, we're talking about a group of individuals who are fragile, who are in much need of substance abuse and mental health treatment.

This is going to go a long way in identifying who and who is not getting treatment as well as why, so I urge support. Thank you, Mr. Speaker.

SPEAKER SHARKEY:

Thank you, madam. Would you care to remark? Would you care to remark further on the bill as amended?

If not, staff and guests to the Well of the House. Members take your seats. The machine will be opened.

THE CLERK:

The House of Representatives is voting by Roll.
The House of Representatives is voting by Roll. Will members please return to the Chamber immediately.

SPEAKER SHARKEY:

Have all the members voted? Have all the members voted? Will the members please check the board to make sure your vote is properly cast.

pat/gbr
HOUSE OF REPRESENTATIVES

25
April 22, 2014

If all the members have voted, the machine will be locked and the Clerk will take a tally. Will the Clerk please announce the tally.

Representative Dillon, for what reason do you rise?

REP. DILLON (92nd):

In the affirmative.

SPEAKER SHARKEY:

Representative Dillon's vote has been cast in the affirmative.

Will the Clerk please announce the tally.

THE CLERK:

House Bill 5373 as amended by House "A".

Total number voting	143
Necessary for passage	72
Those voting Yea	143
Those voting Nay	0
Those absent and not voting	7

SPEAKER SHARKEY:

The bill as amended passes.

Will the Clerk please call Calendar 246.

THE CLERK:

On Page 14, Calendar 246, Favorable Report of the Joint Standing Committee on Government Administration

**S - 677
CONNECTICUT
GENERAL ASSEMBLY
SENATE**

**PROCEEDINGS
2014**

**VOL. 57
PART 9
2668 – 2992**

THE CHAIR:

The Senate will stand at ease.

(Chamber at ease.)

The Senate will come back to order. Senator Looney.

SENATOR LOONEY:

Thank you, Mr. President.

Mr. President, we have a number of additional items to add to the Consent Calendar.

THE CHAIR:

All right. Let's go.

SENATOR LOONEY:

First, Mr. President, Calendar page 4, Calendar --

THE CHAIR:

Hold on. Let's make sure we're in order, here. Get all our bills on Consent. Please proceed, sir.

SENATOR LOONEY:

Yes, thank you, Mr. President. The first item is Calendar page 4, Calendar 273, Senate Bill 480, 4-8-0.

Next, moving to Calendar page 14, Calendar 435, House Bill 5044.

On Calendar page 16, Calendar 450, House Bill 5371.

Also on Calendar page 16, Calendar 451, House Bill 5373.

On Calendar page 18, Calendar 464, House Bill 5293.

On Calendar page 19, Calendar 471, House Bill 5374.

On Calendar page 20, Calendar 472, House Bill 5380.

Also Calendar page 20, Calendar 488, House Bill 5222.

Moving to Calendar page 23, Calendar 504, House Bill 5309.

Also Calendar page 23, Calendar 505, House Bill 5484.

And on Calendar page 23, Calendar 506, House Bill 5487.

Moving to Calendar page 26, Mr. President, Calendar 519, House Bill 5375.

Also Calendar page 26, Calendar 520, House Bill 5471.

On Calendar page 30, Calendar 542, House Bill 5378.

Calendar page 33, Calendar 558, House Bill 5459.

And also we earlier today had placed Calendar page 37, Calendar 120, Senate Bill 237.

And one additional item, Mr. President, Calendar page 45, Calendar 158, Senate Bill 209.

So this would be our proposed Consent items at this time, Mr. President.

THE CHAIR:

Seeing no objection, so ordered, sir.

SENATOR LOONEY:

Thank you, and if the Clerk would then read the items on the Consent Calendar for verification so we might proceed to a vote.

THE CHAIR:

Mr. Clerk.

THE CLERK:

On Page 4, Calendar 273, Senate Bill 480.

Page 14, Calendar 435, House Bill 5044.

On Page 16, Calendar 450, House Bill 5371.

Also Calendar 451, House Bill 5373.

On Page 18, Calendar 464, House Bill 5293.

On Page 19, Calendar 471, House Bill 5374.

On Page 20, Calendar 472, House Bill 5380.

Calendar 488, 5222.

On Page 23, Calendar 504, House Bill 5309.

And Calendar 505, House Bill 5484.

Also Calendar 506, House Bill 5487.

And on page 26, Calendar 519, House Bill 5375.

Calendar 520, House Bill 5471.

Page 30, Calendar 542, House Bill 5378.

Page 33, Calendar 558, House Bill 5459.

On Page 37, Calendar 120, Senate Bill 237.

And on page 45, Calendar 158, Senate Bill 209.

THE CHAIR:

Thank you. Mr. Clerk. Please announce the pendency of a roll call vote and the machine will be opened.

THE CLERK:

An immediate roll call has been ordered in the Senate.
roll call on today's Consent Calendar has been ordered
in the Senate.

THE CHAIR:

Have all members voted? If all members have voted, please check the board to make sure your vote is accurately recorded.

If all members have voted, the machine will be closed and the Clerk will announce the tally.

THE CLERK:

On today's Consent Calendar.

Total Number Voting	35
Necessary for adoption	18
Those voting Yea	35
Those voting Nay	0
Those absent and not voting	1

THE CHAIR:

Consent Calendar Number 1 passes.

Senator Looney.

SENATOR LOONEY:

Thank you, Mr. President.

Mr. President, would move for immediate transmittal to the House of Representatives of Senate bills acted upon today.

THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

Mr. President, would yield the floor to members for any announcements or points of personal privilege before adjourning and announcing tomorrow's Session.

THE CHAIR:

Any announcements or points of personal privilege? Announcements or points of personal privilege? Seeing none, Senator Looney.

SENATOR LOONEY:

**JOINT
STANDING
COMMITTEE
HEARINGS**

**PROGRAM
REVIEW AND
INVESTIGATIONS
1 – 419**

**2014
INDEX**

REP. MUSHINSKY: Senator Kissel.

LAURA GREEN: It's important.

SENATOR KISSEL: Yeah. I just want to say thank you, so much; another -- another important story. And I'm hoping that you weren't lucky be, you were not unlucky because people just had a predetermined notion that they weren't going to hire anybody in your age category.

LAURA GREEN: There is certainly no way of knowing that. Someone would have to be an idiot to say that.

SENATOR KISSEL: That's true; they won't come out and say it. But -- but it seems like things have worked out for you, so I'm really very happy about that.

And I want to associate myself with the remark of Chairman Mushinsky; we are going to need your -- your group's efforts to help push things across the finish line in this short session.

LAURA GREEN: Yeah. I think that I can speak that we will be there. Thank you.

REP. MUSHINSKY: Thank you for coming.

LAURA GREEN: Sure.

REP. MUSHINSKY: Next speaker, Karen Zaorski, from Wolcott Crossroads, followed by Ken Welch, Wallingford Coalition for a Better, Coalition for a Better Wallingford.

KAREN ZAORSKI: Hi. Good afternoon, esteemed Chairmans and committee members.

HB5371

HB5372

HB5373

HB5374

My name is Karen Zaorski, and I'm from Wolcott.

My son Raymond died a cocaine overdose on September 9th, in 2010. Today, I'm here representing members and executive board committee people from Wolcott Crossroads, Incorporated, in Wolcott, and Connecticut Turning to Youth and Families.

We'd like to congratulate this committee on its dedication to what life-and-death issues for Connecticut young adults and families struggling with substance abuse disorders.

In 2012, I came to the PRI Committee to encourage your members to do whatever was necessary to affect policy changes regarding the critical dilemmas associated with barriers to addiction treatment for this vulnerable population, regardless of their insurance coverage.

It is clear that time, concern, and hard work has been invested into researching solutions to the barriers of early intervention resources, access to age-appropriate drug use disorders treatment, and recovery support programs. You have gotten down to brass tacks and implemented some recommendations based on your committee's report and are about to roll out some of your plans in the form of House Bills 5371, 5372, 5373, and 5374, which we hope all are good starts to better and new solutions.

Members of the organizations I represent have already attended focus groups initiated by Department of Children and Families, so we are well aware that thinking caps are in place for how best to ensure that the system cracks are narrowed in order to better save lives. We desire a voice in more meeting rooms.

My main purpose in being here today is to thank you from the bottom of my heart for listening and recognizing that there is an epidemic of drugs in our community and this country and that our young people and families are being impacted in the saddest ways imaginable. With your continued, diligent work, we hope you will make it possible for more individuals and families in this state to timely secure appropriate help for their loved one when they need it most.

If there is any information that our organizations can provide to assist in moving these bills forward, please don't hesitate to contact us.

REP. MUSHINSKY: Thank you for coming back. I'm --

KAREN ZAORSKI: You're welcome.

REP. MUSHINSKY: -- sorry you lost your son.

KAREN ZAORSKI: Thank you.

REP. MUSHINSKY: I lost my brother so I understand.

KAREN ZAORSKI: I remember that.

REP. MUSHINSKY: But you're right, we are going to have to keep together as a coalition and move these bills, especially through the two money committees. So if we don't have your e-mail, please leave it with us.

KAREN ZAORSKI: I will.

REP. MUSHINSKY: And we can contact your organization through you as these bills move out of our committee into the other committees.

KAREN ZAORSKI: Okay.

REP. MUSHINSKY: Because it is a short timetable on the, in the even-numbered years.

KAREN ZAORSKI: And we're ready and willing to help, so we would --

REP. MUSHINSKY: Okay.

KAREN ZAORSKI: -- appreciate getting those calls.

REP. MUSHINSKY: Okay. Thank you, very much.

Questions?

Senator Kissel.

SENATOR KISSEL: Yes. And again, I just, as Co-Chair of the committee, want to say thank you. Actually, when you came and you sat and you started speaking about your loss, of which you have my deepest sympathies, I --

KAREN ZAORSKI: Thank you.

SENATOR KISSEL: -- recall your previous testimony. And it's hard. And -- and it's hard to come the first time.

KAREN ZAORSKI: Uh-huh.

SENATOR KISSEL: Here you are a second time, so it's great to know that you're still with us on this journey, and as Chairman Mushinsky said, we're going to need everybody, rowing together, to -- to make sure these things are a success, especially when it comes to -- to some of the money issues. But I think we can get there. So --

KAREN ZAORSKI: I think --

SENATOR KISSEL: -- thank you.

KAREN ZAORSKI: -- that you can, too, and I think that together, that's the key.

I appreciate your work. Thank you, so much; keep working hard.

REP. MUSHINSKY: Thank you.

KAREN ZAORSKI: You're welcome.

REP. MUSHINSKY: Ken Welch, followed by Eileen Grant.

KENNETH WELCH: Welcome, Chairpersons Mushinsky and Kissel, Senator Coleman, and Representative Carpino.

My name is Ken Welch, President of the Coalition for a Better Wallingford, a grassroots organization formed on the heels of an outbreak of substance abuse deaths, 53 over a three-and-a-half year period in our Town of Wallingford.

I'll be addressing Bills 5372, and 5374. My comments speak to the use of the word "comprehensive" in these bills. Today, this problem has made headlines in many communities throughout our country, our region, and the state of Connecticut. The identification of support services in the face of dying members of our community has been an overwhelming task for our organization.

Complications to our efforts start with the stigma of the perceived self-inflicted action

ERIC HAMMERLING: I'll -- I'll take you based on what you said, which is adding a golf course to a state park. I -- I would say that we're much more comfortable adding a golf course to a state park than taking a -- a piece of a state park that might be a forest and other use and converting it to a golf course; I think that's a -- a little bit of a different situation, but -- but I -- I agree.

And -- and having read the report, which I think is excellent -- and I, I meant to commend the staff for really doing an -- an excellent job on that -- I -- I think we are not taking advantage of those types of opportunities, and there are lot of them out there, so I hope we will.

REP. MUSHINSKY: Okay. So conversion, no, but addition of an existing golf course --

ERIC HAMMERLING: Yeah.

REP. MUSHINSKY: -- would make sense to you?

ERIC HAMMERLING: Yup.

REP. MUSHINSKY: Okay.

ERIC HAMMERLING: Yup.

REP. MUSHINSKY: All right; thank you.

ERIC HAMMERLING: Thank you.

REP. MUSHINSKY: Next speaker is Rich Figlewski, followed by Ana Gopoian.

RICHARD FIGLEWSKI: How you doing?

I'm Rich Figlewski. I'm the Executive Director

HB 5371

HB 5372

HB 5373

of The Dry Dock; I'd like to thank you all for stopping in.

I'm here to speak on behalf of Bill 5371, 5372, and 5373.

Four years ago, in this very room, when The Dry Dock started, I spoke to the town at a Red Ribbon Week Celebration, and we talked about prescription drug overdoses in our community. At that time, I told them there was an epidemic of heroin use in our town; there are, and that has not stopped.

The 53 people that are referenced earlier in this testimony, the reason that we got those numbers is that we sat down and went through the medical examiner's records to find them. The medical examiner is at least six months behind in posting the -- some of those people were people that we know specific who died from drug overdose that had been at The Dry Dock.

For those of you who don't know, The Dry Dock is a safe and sober environment in the Town of Wallingford. If you're looking for initiatives for communities on what to do about how to step up their information to the community and to help people, I think you, a good example will be look at the Town of Wallingford.

Four years ago, we had, The Dry Dock supported a, an awareness night for the people who had passed, a vigil for the people who had passed from drug overdose in the Town of Wallingford or anywhere, really; eight people showed up.

During the Red Ribbon Celebration of last year, we had well over 250 people. We had the clergy; we had many, many people involved. The Coalition for a Better Wallingford, Wallingford

COMMITTEE

Youth in Social Services, The Dry Dock, the superintendent of schools have all gotten on board to let people know that there is a problem here. And we don't want any more people to die; young people, old people, whatever.

The, right now The Dry Dock runs 22 classes in the high school, our Faces of Addiction program. We have Narcan trainings. I think, to go back one step, when you talk about here in Bill 5371, you talk about your statement of purpose. To read it, it says to require state agencies develop or explore certain existing or future programs in order to provide more efficient and effective services to youth, adolescents, and young adults in the state who suffer from behavioral or substance abuse issues. If you're interested in doing that, I would love to see what happened in the State of Vermont happen in the State of Connecticut, where the Governor spent his entire State of the State Speech addressing substance abuse in his state.

The issues of heroin addiction, heroin epidemic is throughout the Northeast, throughout the East. Unbeknownst to me when I started The Dry Dock -- I've now been, started to do interventions, as an interventionist throughout the country, because I've been asked by certain treatment centers -- heroin is epidemic all over the East Coast. It's not just Wallingford. It's name whatever community you're from -- I'm sorry I don't know it -- but I guarantee you I can walk into your town and I can find heroin in 15 minutes.

The, there's a, in recovery -- I'm a recovering alcoholic; I'm a recovering drug addict -- in recovery rooms throughout this country and

throughout this state, there's a thing that's said quite regularly. A definition of insanity, being, doing the same thing over and over again and expecting a different result; what I've seen is the same thing being done over and over and over again.

2-1-1 system was mentioned here. The 2-1 -- if you're in the midst of a, you've gotten out of the hospital, you're out of detox and you're trying to get someplace, trying to negotiate the 2-1-1 system does not work. You can't do it.

The -- why -- the thing about a -- a frequent flier and what constitutes a frequent flier. There's no written testimony from me here today because I was in the emergency room last night and this morning with another person that this is their third-or-fourth trip to the ER. I've never seen anybody approached about getting help from anybody in an emergency room, and I'm there pretty regularly. The, what I see is okay, you're physically stable, get out. Here's a piece of paper. Here's some phone numbers. If you don't die, we'll see you again.

When you call for a bed, detox or rehab, state facility, there's very few times that there is a bed; I haven't heard of one in a long time. Normally, the answer is there are no beds or call back tomorrow, or they'll be a bed in 40 days. If you're struggling as the people that I see every day, 24 hours a day, 7 days a week -- my cell phone never stops; I don't take days off -- what we see is exactly what you're trying to address. Programs where you can call and get help, where somebody will answer the phone, where somebody will actually care are nonexistent in the state of Connecticut.

Do I mean that people don't care? No, I believe that they do. I could hear it; they believe they care deeply. But unless you're in the hell that these families and individuals are in and see the hell and feel it, you have no idea what it's like. And these people are dying around us every day, emotionally, spiritually or physically.

Things can happen. I would love to see some changes. Whatever The Dry Dock, whatever I can do, whatever the people from the Coalition for a Better Wallingford can do, just ask; we're always around.

But I'd like to thank you all for coming to the Town of Wallingford.

REP. MUSHINSKY: Thank you, Rich, for coming again to testify.

I had the same experience you had, where people were basically just stabilized, and then when they were medically ready to be released, they were released, even though there was no bed. And I was very upset by that because there's a really good, odds are really good that there will be a relapse between when they were discharged and when the bed is open, especially if it's a long enough period of time. So I'm with you; I don't think that 2-1-1 is effective to place people either.

We -- we did recommend, in 5371, a single urgent care system for individuals and it, all three agencies would send people there, and the whole system would be interconnected, as the military does now. So do you have any thoughts on that, whether you think that would work?

RICHARD FIGLEWSKI: Yeah, I think that it, some place where people know they could go and there would be someone there to address the issue. If I'm, if I finally say I've had enough, I need to get some place now, not in two days, not in five days, not in forty days; I need to get there now. Because if you lose that window, my only recourse on how to handle my life is with substance. So if I'm not given the opportunity when I'm willing, you're going to lose me. So there has to be -- and it needs to be personal contact -- that someone actually cares.

The, when you have people, I mean the person that I -- I was with today, in the past three weeks, this is her fourth trip to an emergency room, including a two-week stay at Yale Psych -- or for a fifth trip -- and today was she was let out because she was medically stable. Within two hours, she was loaded again and needed to go back to their ER. That's, happens over and over again. And she can't find a bed; there are no beds available for her. And so her, what happens is she goes, maybe gets 24 hours, 48 hours, and the next thing you know, she's off and running again. I mean, there has to be some place for -- for them to go.

REP. MUSHINSKY: I don't know if you heard the, some of the previous testimony, but Middletown, according to our research staff, Middletown -- Middlesex Hospital in Middletown is doing intensive case managements right there in the emergency room.

RICHARD FIGLEWSKI: Yeah.

REP. MUSHINSKY: And they're having good success with it, so I know you, we don't see it yet at MidState, but --

RICHARD FIGLEWSKI: Well it's interesting. And -- and I know of that program, and it's a great program. Having someone in recovery in the emergency room, whether they're ignored or not, the people that are in recovery that are willing to step up to the plate could care less whether somebody wants to talk to them or not. They're there in case they do. Their feelings are not going to get hurt if somebody doesn't want to talk to them.

Many times -- and we've gone to MidState -- I've asked to be, bring volunteers at MidState, that we would just go. And if they need help, if somebody comes in, we'll just sit there; no was the response. I've been at ER enough in MidState where the doctors and the nurses -- mostly nurses -- know me well enough that if I am there with somebody and they're kind of okay and there's someone around the corner, they'll come and get me and I'll go talk to the person around the corner and see if there's something I do for them. But I know that that program is at -- at Middlesex.

I also know that there's a guy at Yale, that's in recovery, that's been there for a long time. And Yale finally made it a paid position; that's just a couple years ago, I think. Ana might know that answer to that better than me.

You have 80 percent of the, I mean, you have 80 percent of the prison population is there because of drugs, whether it's specific that they're specifically that time or it's the guy that stole, you know, broke into a house. Ninety percent of your domestic violence cases revert back to drug and alcohol abuse.

Sometimes I wonder if -- if the interest is in

actually solving the problem or are people afraid that too many other people are going to lose a job if you try to actually address the problem. I mean, an example of that is you have -- as I was kind of taken aback by -- we're looking at a bill here, 5372, in reference to the Alcohol and Drug Policy Council that hasn't met, except for twice in two years. So how much money? Maybe we could get a bed for somebody as opposed to worrying about this for somebody for -- for a committee that hasn't met in two years. And I understand people are busy, but it kind of gets frustrating when you're out here.

The Narcan stuff that went through a couple years ago, doctors don't even know that they can prescribe it. And, you know, there should be a Narcan kit in every police car, in every -- every place that there's an adfib, a defib machine -- what's your, adfib or them, defib, one of them -- there should be a Narcan kit.

REP. MUSHINSKY: Okay; thank you.

RICHARD FIGLEWSKI: Okay.

REP. MUSHINSKY: And just so you know where we're coming from, this -- this 5372, we're -- we're actually trying to synchronize these commissioners. They all have clients that go through their doors that are affected in the same way. And they all should be, in our opinion, they all have to work together to have intensive case management for these clients, who sometimes are under DSS; sometimes they're under Mental Health and Addiction Services; but it's all the same person. So we want the coordination to be the same.

RICHARD FIGLEWSKI: I -- I didn't mean to smile when

you said "synchronize"; I just had this vision of all the commissioners in a pool, synchronized swimming. So that, you have to -- which could be more entertaining -- you probably got a better chance of them showing up if you do that.

REP. MUSHINSKY: Well, you know what we're getting at is we're trying to have a seamless system, so that no matter how you come in the system -- you came in through DMHAS or you came in through DSS or anywhere else -- you're going to get served quickly; that's the idea.

RICHARD FIGLEWSKI: And I don't mean to sound like, and I don't mean to sound like I don't appreciate what you guys are trying to accomplish and what you're trying to do, because I really do. It's -- it's just frustrating when you're out on the street every day dealing with this, how many hurdles you have to watch people jump through.

REP. MUSHINSKY: Yeah.

Questions?

Senator Kissel.

SENATOR KISSEL: I just want to say thanks, again for -- for being so passionate and coming here again. I remember last year you were here and you were just as passionate, and that was during that big snowstorm that we had. And so although I must say if you're doing this 24/7, you need to have a little time off, otherwise you'll burn yourself out. This is a --

RICHARD FIGLEWSKI: Yeah, I've heard that before.

SENATOR KISSEL: This is a really, this is a tough

thing. So -- so give yourself a little breathing room and -- and then you'll come back even more recharged, because -- because what you're doing is -- is God's work; it's hard, hard work.

And the bureaucracy, it doesn't have an ill will, but it's -- it's just sometimes very immovable. You know, and I'm not saying in some instances there's -- there's areas where obstacles are put up on purpose; if we make someone knock ten times, they may give up after nine, but quite often it's -- it's just more something set in motion. It has a life of its own, and, you know, we're trying to get our arms around these things.

But I think Chairman Mushinsky just hit the nail on the head, where trying to get sort of a -- a seamless system that it doesn't matter how you come in, that what happens to you thereafter is equal. And it's just not easy. It's just not easy. I mean, you have fiefdoms, you have agendas, you have different computer databases, ways of filing paperwork, how different agencies operate, and try to bringing that all together, and then you have nonprofits and for-profits. But we're not going to stop until we get there.

Thank you.

RICHARD FIGLEWSKI: Thank you.

SENATOR COLEMAN: All set.

REP. MUSHINSKY: Thanks, Rich.

RICHARD FIGLEWSKI: No problem.

REP. MUSHINSKY: Ana Gopoian, followed by Peter

Stauble.

ANA M. GOPOIAN: Hello and good afternoon.

I'm Ana Gopoian and this is my first time at this platform or any of this kind, I should say that. But it's very nice that my grandmother welcomed me; she's the bottom, left corner of that quilt behind you, so I guess that was my little, my little God shot right there.

Let's see. I'm here for many reasons but specifically the four bills that have been brought to my attention that I think I have something to say towards, hopefully to be part of the solution, 351, 5 -- yeah -- 5371 -- I'm sorry -- 5372, 5373, and 5374. I think they work together in regards to, you know, they're, it's multifaceted.

I'm a registered voter. I'm a taxpayer. I'm a homeowner. I grew up in the Yalesville side -- if we need to segregate in that way -- of Wallingford; I grew up here. I went to some of the school systems here; you know, baptized, first communion, confirmation. My -- my family was reputable in this town.

Ah; thank you. I brought tissue but I thought if I didn't bring it, I wouldn't cry.

REP. MUSHINSKY: I'll share. I'll share my water with you.

ANA M. GOPOIAN: Oh, thank you; this happens pretty regularly, and it's okay. And it's okay. I've spoken on many platforms, meetings in this town, many hundreds of meetings in this state, this country, outside of this country, and recently for a world conference. And what I haven't mentioned is I'm a woman in long-term

recovery. Okay; thank you.

My mother has a year and a month less clean time than I do, and because we had the right last name and lived in the right town, in the right community, things couldn't be happening to us. The stigma that has been mentioned more than once here, the changes that are necessary within our system, not just this town but in this state, I am directly affected, and -- and not from the now 18-and-a-half years in my recovery program as a long-term, you know, member of life and society.

At the age of six, there was already trauma going on that didn't have a vocabulary, in a school system that didn't pay attention then. I'm 50; I still feel that pain. By the age of 12, I was already participating regularly in substance abuse, but because of my last name and the inability and lack of education, nobody knew what to do. It wasn't just that; it was not knowing how to read well and getting pushed through a system. It's not using the system because we're embarrassed as a family.

What was mentioned -- I haven't even looked at my paper; sorry -- what was mentioned earlier, a couple things -- they kept coinciding as we go on -- and I will go over that beep 10 times over and as 53 lives have been lost in the last 3 years. You know, I think it was said last year at the Red Ribbon, 93 over 10, and those are just the ones they can find. And then you had mentioned that sometimes it's about 3 years to pass a bill and make a law or -- you know what I mean? If you collectively looked at that information and brought that to the table, you are directly going to attach and affect everybody at that table, one way or another, personally or indirectly.

I know for me and -- and how I've been able to get involved within my community, and I heard "you're angry" to a couple people that said, Yeah, we're angry, but that's where the -- the greatest advocates are born. So I am here angry. I am here because my phone blows up on a regular basis, and it's, directly affects me as a -- a person and a woman and a member of a recovery community. I -- I do field and learned how to balance my life with the other, extracurricular things.

I've learned to read, and I went back to school; and I got a degree, and I'm just starting. When I look at these policies and the things that are being asked for us to come here -- I haven't even looked at this thing -- I've been able to show up and -- and made new friends; Crossroads, Karen is amazing. Karen, I was invited to the board for the Connecticut Turning to Youth and Families, another amazing organization, and -- and I will feel very comfortable continuing forward with everybody that seems to be getting put right in my path.

The Coalition for a Better Wallingford hired me -- me; don't you know who I am? Don't you know what I've done? I get to give back to the town that I wreaked havoc on. What a greater opportunity, I don't know, but its desperate cases are coming to these groups. And they're not just looking for hope; they're desperate and beaten down. And we tell them to do X, Y, and Z or we understand, and we turn them over to a system that's not there for them.

As someone in recovery, I have taken people and got them loaded to get them into treatment. They're not high enough is not what you want in that window of opportunity. I know that peer-

to-peer support makes an incredible difference. I know the education, not just for the people needing recovery but the people have not maybe crossed the path of its wrath yet. Attached to those 53 people in the last 3 years are 53 families. You cannot let people leave treatment or get, after 3 days or stabilized or whatever they're calling it and tell them to go home into an environment that might be just as dysfunctional as a crack house or a -- a heroin den or -- it's not just one drug.

It's amazing things or, can happen, amazing things can happen. You have the soldiers. We're here, the peer-to-peer support. I have become a recovery support specialist and other things. I've become a lot of things. I carry many labels and many hats, and I'm incredibly grateful to take people along. What we can teach the youth are the skills needed for this, the -- the services and -- and building careers, advocacy and learning about these things, communication and education. Those have career paths attached to them, a purpose attached to them, a place to go on a weekly, regular basis attached to them.

But demographics are getting younger and younger, and they're coming, and they're becoming more and more creative. As much as I have passion for the things in society I would have never cared about before, it's really hard to sit and listen about some of the other topics and how they're collaborated in and integrated together when you can talk about the things that I love to participate in, like the forest and the parks or -- or older, elderly people -- I'm on my way to being elderly because I choose to live well; right? So like -- and then you got to talk about the life-and-death crisis, epidemic. It just doesn't even

seem like it should be on the same platform.

I -- I can talk a lot. I didn't talk for years. I didn't talk for years, and now I think I have something worth talking about. In my 18-and-a-half years clean, I have worked hard on myself. And I'd like to reverberate that you can't just leave a treatment program, if you've been so lucky to get in one, and be well. There's at least a year necessary before you've been able to start altering the patterns and behaviors of the people that have survived.

I was 32 years old when I got clean. My things started very young; 6, picking up at 12 I made my first phone call at 23 to a help line that I didn't reach back to, and I suffered for 9 more years until I found this program. And now I give back on a regular basis because it -- it fills my spirit and people are surviving and thriving. I am no longer a victim; I am the avenue to what's possible. And I think the greatest power against the disease of addiction is living well, but if we don't have the resources and the safe places to do that, we're in trouble.

So take my number. Take my e-mail. I don't have any fancy phone or Facebook, but -- and I can even hand this paper in, which I will -- I have a lot to say and I'd love to support anybody else that would like to listen and/or, you know, have your child. Give me your parents; I don't care. I'll keep talking until this epidemic is addressed, you know.

Thank you, so much.

REP. MUSHINSKY: Thank you for your testimony, very heartfelt. And thank you for working for the Coalition for a Better Wallingford; I think

they chose well.

And I think you agree with us that there's still gaps in the system when you take somebody in and they're treated temporarily for the weekend. They're not safe unless they go directly into a treatment. Coming home again is not safety. So I think you're reinforcing what our experience has been too.

ANA M. GOPOIAN: And our state, unfortunately, farms people out -- and let me say that as horrible as it sounds -- they farm people out of the state because that we cannot be served when in our own state.

I've told parents to drop their children from their insurance because they can get better services with none, and these are hard-working people.

REP. MUSHINSKY: Uh-huh.

ANA M. GOPOIAN: These are people that pay for insurance and thought they were safe to serve their families. And I'm, and I'm trying to teach them how to break their part in the hold; you know what I mean? And --

REP. MUSHINSKY: Yeah.

ANA M. GOPOIAN: -- be who they need to be.

REP. MUSHINSKY: No, we found the same thing, when in our research we found that the state system did a better job than the private insurance of taking --

ANA M. GOPOIAN: Uh-huh.

REP. MUSHINSKY: -- care of kids with addiction. So

we found the same thing.

Anyway, we -- we do appreciate your coming in and testifying. I know it's hard and appreciate that you're strong enough to do that. And even if you just send one copy of your testimony, that's fine; we can scan it in. And if you want us to get in touch with you as the bills move --

ANA M. GOPOIAN: Uh-huh.

REP. MUSHINSKY: -- give us your e-mail too; okay?

ANA M. GOPOIAN: Thank you.

REP. MUSHINSKY: Questions?

Okay; thanks.

ANA M. GOPOIAN: Thanks.

REP. MUSHINSKY: Next witness is Peter Strauble, Struble, followed by Efrain Madera.

PETER J. STRUBLE: Good afternoon, Madam Chairman, committee members.

My name is Peter Struble. I'm a resident of Wallingford, recently retired as the fire chief here in Wallingford. And the Wallingford Fire Department is, provides emergency medical services, paramedic services and transport to emergency departments. Now I'm working with the University of New Haven, doing work with prehospital care in paramedicine.

I'm speaking in support of Bill 5378, at least in concept, as it raises an important discussion we must begin to have about health care. My purpose in testifying at this hearing

one of the things we discuss in the testimony -- and that's addressed pretty extensively in the report -- is that it really isn't just DCF who bears a responsibility for these children, because by virtue of the fact that they're aging out of care, many of them will be transitioning to the support of other state systems because of the trauma and other things involved with their foster care experience. And so we really think that it's important that, at minimum, DSS, SDE, DOL, and DOH are able to address the health care access, education, labor, and housing concerns of the report and that the report also be submitted to the relevant committees of the Legislature that have oversight over those agencies.

REP. MUSHINSKY: Okay; that's explicit enough. Thank you.

Are there any questions? Nope.

We'll check out that bill in the Children's Committee.

KENNETH FEDER: Yeah. Thank you, very much.

REP. MUSHINSKY: Dr. Laine Taylor, followed by Sonya Wulff.

SB 202

LAINE E. TAYLOR: Good afternoon. Thank you, so much.

My name is Dr. Laine Taylor; I'm a child psychiatrist. I'm representing the Connecticut Council of Child and Adolescent Psychiatry. As a child psychiatrist, a Connecticut resident and a, an advocate for children, I am speaking in support of House Bill 5371, 5372, 5373, and 5378.

As very well stated by Ms. Giordano, the greatest gap for access to mental health care within the state is from middle-class families with private insurance. The accessibility to provider's programs and the adequate length of treatment hits our working-class families the hardest. Connecticut has a safety net for its poor through the use of HUSKY, and the wealthy of the state are able to access fee-for-service treatment. This gap in care is relevant for all medical care but impacts mental health care to a greater extent. We're enthusiastic about the efforts within the state, both within the Legislature as well as the Governor's Office to improve access to mental health care.

With regards to House Bill 57 -- 5371, we'd like to speak, specifically speak to the in-home services as well as reporting by private insurances. To make this really brief -- it's been a long day for you guys -- we'd like to support the report, reporting the use of state funding for in-home services by those with private insurance, to provide the state with information and determine further necessary steps to make this service accessible even within that access gap I just mentioned.

In-home services are crucial for many families, and it's only accessible to those who have HUSKY insurance. Even private-pay, you're unable to access it. Many of our families wind up having to utilize our state funding in order to access in-home services.

With regards to House Bill 5372, I want to speak specifically to substance abuse. And as a clinician who cares for children and families who struggle with substance abuse, hearing the testimony earlier today from those who -- who

are in recovery and are able to speak on behalf of so many who can't, I'd like to really partner and -- and thank them for their testimony. We as providers, we fight this battle alongside them with regards to addiction and treatment services.

We at CCAP support the development of a council in administration to review policies and access to substance abuse cures for all, all individuals. There is a deficit of services for individuals who struggle with addiction in their families. It is our hope that the policies reviewed and developed by the, by this committee that is proposed to be developed will promote access and implementation of evidence-based treatments. With that in mind, we would also like to recommend that considering a clinician who actually is knowledgeable about evidence-based treatments be considered as a part of that team that you guys are developing or proposing. We think that without the use of someone who has actual treatment knowledge, that many of the policies may not be targeted well enough to those who really need it.

With regard to House Bill 5373, we are also in support, as this bill improves on transparency of the policies of individual and private insurance. Regular reporting of insurance practices to the state will not only allow policy holders to be aware of the practices of their and other insurance companies but it will provide data for future improvement of care.

In recent years, the reporting of this data to various legislative task forces supplied policy makers with factual information as they evaluated the efficacy of programs and previous legislation. We believe that the transparency will best serve the public and private sectors

while, most importantly, serving our children and families' quality of service options. So thank you for that.

Finally, with regards to House Bill 5378, there are two areas in which we'd like to comment. Firstly, we'd like to make a comment on the telehealth demonstration project. We're very much in support of this and we actually think the telehealth and telemedicine services will greatly increase access to care, both within our urban and our rural communities here in the state of Connecticut.

Many states are already utilizing telemedicine and telehealth, and as a child psychiatrist, specifically there are pilot programs that have been developed by Value Options through Yale University to improve, as a, as a pilot program for primary care connecting with child psychiatry subspecialists.

So we are very much in support of this and we would like to specifically recommend that the language not include the use of "audio telephone" and "facsimile." There's also a similar bill, Senate Bill 202, which is being discussed at the Insurance company -- Committee on Thursday.

Lastly, we're in support of the extension of Medicaid Insurance for up to one year after a family no longer meets criteria for this program. Many of the children and families that we serve utilize programs only offered if coverage is provided by HUSKY Insurance. We want to encourage the families to not rely on state funding for care, but an abrupt change in payer often means abrupt change in availability of services.

GAIL DeLUCIA: I appreciate it.

REP. MUSHINSKY: -- ranked it. You will; you have enough enthusiasm and energy that you will be, you will make it.

GAIL DeLUCIA: Thanks, so much.

REP. MUSHINSKY: Okay.

Susan Campion and Bobbi Fox, and' then our last speaker will be Carol Renna.

Are you guys splitting the three minutes or how you doing this?

SUSAN C. CAMPION: We'll probably split three minutes --

HB 5372

HB 5373

REP. MUSHINSKY: Oh.

SUSAN C. CAMPION: -- once we get going, but we will keep it within.

First of all, thank you, so much, committee. You have been so generous with your time to all the individuals who came forward, and you should be commended for that.

I'm -- let me introduce myself -- I'm Susan Campion, and I'm President of the Connecticut Association of Addiction Professionals. We represent the credentialed addiction specialists who number about 1,800. We're an all-volunteer association. This is --

BOBBI FOX: I'm Bobbi Fox; I'm the Vice President of "CAAP," we call it.

SUSAN C. CAMPION: What we call CAAP. And we're

here to comment and ask your consideration on two bills.

First of all, the licensed addiction specialist meets the most rigorous standards both on the state level and then formed by national standards. We must mention that we are the only affiliate of the National Association of Drug and Alcohol Abuse Initiative.

We have heard such gut-wrenching testimony today; that's what the folks that we represent deal with every day. I've been around for about 35 years, so I'm an old veteran in the trenches of addiction treatment and mental health treatment. And I got to say some of the stuff sounds very familiar, the Alcohol and Drug Council policy and studies and studies.

Time is the enemy of addiction. Addiction is a primary disease. Help is not on the way; we are here to help. We have the very skill sets that you're asking the council to have training and investigation in from other collateral professionals. Every day I or my colleagues consult with M.D.s. We might have a 45-year-old lawyer who has now been arrested four times for prescription use and is serving time; a school counselor who is working with a family who was just ready to disintegrate because of prescription substance abuse; we're on the front lines. We know what is happening.

We don't need anymore studies; we know what is going on. The system is broken. I'd like to speak to the fact that one of the greatest barriers and -- and folks said it so eloquently, I -- I could not come close -- our focus, addiction, is a disease of stigma and shame, and people are treated like that. And, in fact, even our system in the state is a -- a

negative shame-based system. You have to fail at outpatient treatment. You have to fail in intensive, outpatient treatment, and then, if you're very fortunate, you may get a bed. This is what we're dealing with in 2014.

For some reason in our state, addiction has become a second-tier disorder, and yet without qualified professionals, trained professionals, we cannot do, expect outcomes in mental health where folks are required to attend treatment, take psychoactive drugs. Their families comply; we cannot expect positive medical outcomes when there is active addiction. Addiction is a primary disease.

So the last point that I would like to make is -- and then I'll get to what we're requesting -- is our insurance system. We are the fourth-highest state for insurance rates. I don't have to tell you this; you get calls from your constituents every day. And yet the Medicaid rate for a provider to see somebody -- and by the way, folks on Medicaid tend to be more complex; they usually have active substance use, preexisting psychiatric illness, and many times very severe psycho-social issues, complex cases -- they get \$42; that's their reimbursement rate.

Now this isn't for our field, certainly for anybody that I've met, and I'm so blessed to be part of this group. It's never about money; it's about holding out a hand for somebody who is activity dying. And we are now, in Connecticut, moving into a whole new era of health care with the advanced home medical model, with the look at hopefully implementation of the parity bill.

I ask you tonight to consider -- I don't, first

of all, I want to have a question. How long has this council? This council has been around for a long time, and, again, people are dying. And getting back, I -- I get, I get very emotional because I'm thinking about a case I was -- was called on over the weekend about. But, in any event, what I wanted to say is that we're rationing care. We've done an, agencies are called on to do utilization studies until they, their computers break down. It's not fair; they don't have the time or the effort.

I think if a recommendation that we have is that the parity act be really looked at and followed. We don't punish somebody, a teen or a youth for having a diabetic shock or having a consequence, a medical consequence for their disorder. We don't punish them.

In the state of Connecticut, if you relapse or if you don't complete treatment, you are punished; and that has got to stop. I commend the State of Vermont; I commend that Governor that took tremendous, tremendous courage. We are all in this together, and I know by reputation each of you has a -- a tremendous investment in the welfare of our great residents. But we have problems.

So two, I would conclude with these two recommendations: We have the skills; we're not even mentioned in the bill, but you're going to train physicians and you're going to train -- which we've done. We do that. And you're going to train some doctors; wonderful. We need all the help we can get. It's a big problem. But we would ask that the association be a member of this policy council, alcohol and drug policy council. We are the lead provider by statute and training. That's one recommendation we have.

Secondly, for some reason -- and my testimony will go into evident-based -- we had, I, we are not always included on insurance panels. So I would ask you, if you had a cardiac problem and your insurance company said, Well, I'm sorry, sir, you're going to have to see Dr. Jones who is a wonderful gastroenterologist; he can do the job for you because he's on your panel. So and our group requests that we be recognized at the lead provider for addiction services; simple; simple; simple. We -- we do evidence-based treatment. We confer with specialists on the stage of the disease and the progression of the disease and addiction. We know how to do brief intervention; our field invented it back in the nineties.

We, I, myself, work with very high-level criminal justice clients; believe me, when people have good treatment, you see results. So, again, you are so generous with your time and your commitment, but would you ask the Alcohol and Drug Council because how long they've been around and if some of these studies haven't come down there. Because I think I've seen them before. I think I saw them in 2000. I think I saw them in the 1990s. And I don't mean any disrespect.

I will tell you, the workforce analysis that some of this material has come from is ten years old; SAMHSA did this in 2004, and it's, and it's in my evidence. So -- so I would refer you to this. This is not news.

So we want to help; we are here to help.

BOBBI FOX: I just want to reiterate what Susan had said. My name is Bobbi Fox, by the way and I'm a professor at Manchester Community College,

and I train addiction counselors. I give them degrees as a first step; they only get associates. But I, part of my job is encouraging them to enter the field of addiction counseling, and that your goal would be a license; because today, in today's world, licensure means reimbursement by providers.

And in these two bills, 5372 and 5373, 5372 mentions the Alcohol and Drug Policy Council. I've been in this profession since 1980; I never heard of it until I saw this bill. I never heard of this council. And I'm active in politics. I'm active at my job, but I never heard of this council. So I'm going to guess it's not a very productive council; I'm just making a wild guess here. And from what I -- we did a little whispering with Pat Rehmer, the Commissioner; she concurs. So my recommendation would make it a viable council and make it with people who want to be on it.

A VOICE: Exactly.

BOBBI FOX: And we want to be on it. We represent the addiction professional in the state of Connecticut; that's our first one.

But the second one, a lot of people don't know our credential. We're a licensed addiction, alcohol and drug counselors. We're licensed by the State of Connecticut. People when they seek someone to reimburse, they go, so where's the social worker; where's the licensed marriage and family therapist -- to do addiction counseling.

SUSAN C. CAMPION: Uh-huh.

BOBBI FOX: And I taught my students this, just last night. And I put all those initials on a board

and I said, Who's the one that you can tell has competence and knowledge in addictions, just by the credential? And the only one you can have is the LADC. You know that they've been to school. You know they got the training, and you know they have the education.

You cannot be assured of that with an LMFT. You cannot be assured of that with a LCSW. We're the lead provider for addiction treatment and diagnosis, and we want you to know that and pass it along.

SUSAN C. CAMPION: Uh-huh.

BOBBI FOX: Thank you.

REP. MUSHINSKY: Thank you for coming.

BOBBI FOX: Thank you for your time.

REP. MUSHINSKY: And do you have any questions?

SENATOR KISSEL: No, I do not.

REP. MUSHINSKY: Oh; okay.

BOBBI FOX: Thank you.

REP. MUSHINSKY: Our last speaker is --

A VOICE: (Inaudible.)

REP. MUSHINSKY: -- Carol Renna. And if there's anyone else who did not sign up that wishes to speak, please come forward after Carol and give us your name.

Thank you.

CAROL RENNA: Good evening.

HB5371 HB5372

HB5374



March 4, 2014

RE: Raised Bill Nos. 5371, 5372 and 5373

Dear Members of the Program Review and Investigations Committee:

We are Traci Cipriano (Director of Professional Affairs), and Barbara Bunk (President) of the the Connecticut Psychological Association (CPA). CPA ***supports R.B. Nos. 5371, 5372, 5373 and 5374.***

Raised Bill Nos. 5371 and 5374 address the great need for access to substance abuse treatment by insured youth, as well as the issue of continuity of care for youths aging out of the state care system. This Committee issued a report which was approved in December 18, 2012, addressing the tremendous inadequacy of substance abuse treatment options for Connecticut's insured youth. In addition, Connecticut's Healthcare Advocate, Attorney Victoria Veltri, released a report on January 2, 2013, which also highlights problems within the system. The mental health and well-being of our youth and those aging out of state services should be a top priority; early intervention through access to appropriate mental health services leads to the best outcomes and increases the likelihood that those youth in need of services will later lead healthy, productive lives.

Raised Bill No. 5372, establishes a Connecticut Alcohol and Drug Policy Council, as well as membership criteria. We note that, other than the Commissioner of the Department of Mental Health and Addiction Services, there is no other seat for a mental health professional on this council. Considering the tasks set forth in the proposed bill (reviewing policies and practices concerning substance abuse treatment and prevention), we recommend adding a seat for at least one additional mental health professional, such as a clinical or counseling psychologist (Ph.D., Psy.D, or Ed.D).

Raised Bill No. 5373, addresses reporting requirements of certain data by managed care organizations and health insurance companies to the Insurance Department. The provisions of RB 5373 increase transparency related to coverage decisions and complaints, which will facilitate evaluation of the review process, including compliance with federal parity law, which requires equal treatment of medical and behavioral health providers and conditions, as well as network adequacy.

Line 19
Page 4.

March 4, 2014 - Testimony of Karen Zaorski at the Program Review and Investigations (PRI) Committee public hearing in support of:
H.B. No. 5371, H.B. No. 5372, H.B. 5373, H.B. 5374

Good afternoon esteemed chairs, Mary Mushinsky, Joe Markley and members of the PRI Committee. I am Karen Zaorski from Wolcott. My son Raymond died of a cocaine overdose on 9/09/2010. I am here today representing the members and executive boards of Wolcott Crossroads, Inc. and CT Turning to Youth and Families. We'd like to congratulate the committee on its dedication to what are life and death issues for CT youth, young adults and families struggling with substance use disorder issues.

In 2012, I came before the PRI committee to encourage members to do whatever was necessary to effect policy change regarding the critical dilemmas associated with barriers to addiction treatment for this vulnerable population regardless of insurance coverage. It is clear that time, concern and hard work has been invested into researching solutions to the barriers of early intervention resources, access to age appropriate drug use disorders treatment, and recovery support programs.

You have gotten down to brass tacks and implemented some recommendations based on your committee's report and are about to roll out some of your plans in the form of H.B. 5371, H.B. 5372, H.B. 5373, and H.B. 5374 which we hope are all good starts to new and better solutions. Members of the organizations I represent have already attended a focus group initiated by DCF so we are well aware that thinking caps are in place for how best to ensure that the system cracks are narrowed in order to save lives. We desire a voice in more meeting rooms.

My main purpose in being here today is to thank you from the bottom of my heart, for listening and recognizing that there is an epidemic of drugs in this country, and that our young people and families are being impacted in the saddest ways imaginable. With your continued diligent work, we hope you will make it possible for more individuals and families in this state to timely secure appropriate help for their loved one when they need it most. If there is any information that our organizations can provide to assist in moving these bills forward, please don't hesitate to contact us.

Most sincerely,

Karen Zaorski, 203-879-5526
36 Hempel Dr. Wolcott 06716

Representing: Wolcott Crossroads, Inc. and
CT Turning to Youth and Families

Line 24
Page 7

Ana M Gopoiian

March 4, 2014

St. Of Ct. General Assembly

Testimony and support of Bills No. 5371,5372,5373,5374

Hello, my name is Ana M. Gopoiian, I'd like to thank you all for being here and giving me the opportunity to give testimony in support of the bills listed above. I grew up in this town Wallingford, CT. baptized, first communion, confirmation and elementary school, junior high, a couple of attempts at high school, alternative school and adult education night school, my family was comprised of two good hard working families, my parents were children having children. I'm now 50, a tax payer, a register voter, a home owner, and last but not least a woman in long term recovery.

I am here in support and also working with CTYF (Connecticut Turning to Youth and Families), The Coalition for a Better Wallingford and new on my path, Crossroads from Wolcott, CT. I believe it is these grassroots organizations that will help support the intentions of these bills and help to serve the young adults, adolescence and their families collaboratively. We are the front line soldiers and we need funds and resources to strengthen the paths to successful treatment, aftercare, housing and education within our state and our communities.

As a woman in long term recovery I've seen our systems dwindle down to nothing over the past 18 ½ years. I had available to me 18 ½ years ago 17 days treatment inpatient and two weeks of an outpatient relapse prevention program I begged for. I was high for 20 years and I couldn't get more time, more support, I didn't have information and my family dynamics were challenged at best. I couldn't get more than the 17 days, but I could discharge, get high and if I lived through it come back for 17 more days the next day. At this time I also worked for the insurance company that carried my insurance plan.

Fast forward 18 ½ years later, IT'S WORSE, really bad! If you're lucky to get into detox it's mostly 3-5 days only to be turned out to the streets after you've stabilized. The possibility of being farmed out of state with no real reentry plan to your community might be an option if you have insurance. If you a hard working family with insurance you're actually so limited that the out of pocket costs are crippling. I have been in position to desperately suggest a parent to drop their young adult children from their insurance because there were more services available to their children. I've taken desperate addicts to get high or higher to qualify entry to treatment; one person openly said they were going to kill themselves just so they had a safe place to be and one facility told an addict strung out on cocaine that it wasn't addictive.

I believe these bills will get the changes needed started in the right direction, helpful in so many ways, affecting so many people. We really need to look at what is already in place in our systems and collaborate, not waste valuable resources and TIME reinventing what so many of us know we need. TIME is wasting, people are dying. If Wallingford alone lost 53 people over the last 3 years to drugs, most of those young adults and it takes three years to line up the powers to be to pass a bill, try wrapping around the reality of 53 people times the number of towns in our state over the next three years...

Many will die or continue to suffer and attached to each one of those people are their families, there needs to be complete care, care that not only treats the person needing recovery but recovery for the families too. Recovery only starts in treatment, it has greater success and it can be sustained when it has the support as any other disease would have.

- Peer to peer support, people with lived experiences and places to share it, including schools, community centers, recovery clubs
- Safe and available treatment in state that is age and gender specific
- Programs that bring into consideration the families and their need for recovery also
- Safe residential programs that are regulated, gender and age specific
- Education on topic and programs in schools with availability in our communities that can also nurture communication skills, life skills, work ethics, integrity, and job opportunities

So even though I had many privileges as seen by society in our small town there were many secrets, and stigmas that assisted in keeping the shame, guilt and disease in control. My mom has a year and a month less clean time than me and I know she has her own pain and story to heal from. At the age of six I had a trauma that had no vocabulary, I felt different and alone, I experimented with alcohol and cigarettes, at 12 I was using other drugs, by the end of junior high I was selling drugs, hanging out with a subculture of like minds. By 16 I was already pregnant once and by 17 I was no longer welcome in my home. I wandered for a while, lived in a car I borrowed and never brought back and tangled with a motorcycle club. I called a 12 step helpline at the age of 23 but never showed up and suffered for 9 more years. By the time I made it to treatment I was 32 years old, I jockeyed many different drugs over time, I had been pregnant four times and I was hopeless. I did acquire a GED along the line but struggled with learning disabilities and reading. There is much more to this story, but I'm no longer a victim of it, I'm a survivor.

I am a responsible productive member of society that lives in the solution today. I am a state certified RSS (Recovery Support Specialist) and I co-facilitate a group for parents of children that are in active addiction or active recovery for The Coalition for a Better Wallingford. I am the first one in my immediate family to graduate college and now have a BA in Social Science, and just recently completed a state certification to be a Hypnotherapist. I believe my path is full of people supporting, guiding and serving a greater good. The disease of addiction has no prejudice; no matter of age, race, sexual identity, creed, religion, or lack of religion, it has no mercy. I believe there is a movement happening though, a movement that will help to break the stigma of the disease of addiction in society and have healthcare and the systems supporting it come together and treat this disease as a disease.

Thank you for your time, thank you for your service and I look forward to continued change on these topics.

Sincerely,

Ana M. Gopoiian

Nalove16@aol.com

203-213-0329

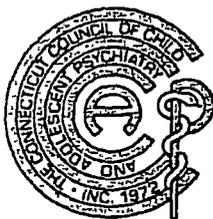
LINE 17
Page 10.

**Connecticut
Council of
Child and
Adolescent
Psychiatry, Inc.**

March 4, 2014

Testimony in Favor of HB 5371, 5372, 5373, 5378

Good afternoon Senator Kissel, Representative Mushinsky and Program Review and Investigations Committee Members



104 Hungerford St
Hartford, CT 06106
860-559-7464
fx-860-727-9863

Officers

Joan Narad, MD
President

Andrew Lustbader, MD
President-Elect

M. Waqar Azeem, MD
Secretary-Treasurer

Brian Keyes, MD
Immediate Past President

Jillian Wood
Executive Director

I am Laine Taylor, DO, and am speaking today in my capacity of Executive Committee Member of the CT Council on Child and Adolescent Psychiatry. The greatest gap for access to mental health services within this state is for the middle class families with private insurance. The accessibility to providers, programs, and adequate length of treatment hits our working class families hardest. Connecticut has a safety net for its poor in the form of HUSKY and the wealthy of this state can access fee for service treatment. This gap in care is relevant for all medical care, but impacts mental health care to a greater extent. The state of Connecticut is realizing the importance and wide reaching impact of mental health and access to mental health care for all individuals over the past year. Much of the effort to improve access has been for children and their families. This is seen in our state legislature's enactment of several laws including PA 13-3 and PA 13-178 which deal in the innovative efforts at delivering mental health screening and interventions to children. This is also seen through the Governor's administrative efforts and collaboration with the Office of the Health Care Advocate. As a Child and Adolescent Psychiatrist, representative of the Connecticut Council of Child and Adolescent Psychiatry, and a Connecticut resident, I am speaking in support of HB 5371, 5372, 5373, and 5374.

Our statements in support of each bill are as follows:

Regarding HB 5371:

As any parent is aware, a child does not exist in a vacuum. The environment of a child includes school, peer interactions, and family. One of our most effective therapeutic interventions is the In-Home therapeutic service. This entails a licensed clinician entering the home to evaluate and address the behaviors of a child within the family structure. It provides the child, family, and clinician with a perspective unavailable through clinic visits. This intervention is not appropriate for all children, but is reserved for children with whom other interventions have been unsuccessful. Currently this is only available to family with HUSKY insurance or DCF voluntary services. The only current access to Intensive In-Home Child and Adolescent Psychiatric Services is through the use of state funding sources. It is the position of the Connecticut Council for Child and Adolescent Psychiatry that this level of care be available to all children within the state, including those with a private insurance payer. Reporting the use of state funding for in home services by those with private insurance will provide the state with information to determine further necessary steps to make this service accessible even within the access gap.

Regarding HB 5372:

The council also supports the development of a council in the administration to review policies and access to substance abuse care for all individuals. There is a deficit of services for individuals who struggle with addiction and their families. It is our hope that policies reviewed and developed by the council will promote access and implementation of evidence based treatments. With that in mind, the council reviewed the individuals named to the council. It is evident that policy makers, the justice department, and social services are well represented. We would like to additionally recommend appointment of a substance abuse medical specialist representative to help the policies to reflect clinically accurate decisions as other areas impacted by substance abuse are represented on this council.

Regarding HB 5373:

The Council is also in support of this bill as it improves transparency of the policies of individual private insurers. With the implementation of the Affordable Care Act, more Connecticut residents will be members of private insurance panels. There are great differences in coverage between plans. Regular reporting of insurance practices to the state will not only allow policy holders to be aware of the practices of their and other insurance companies, but it will provide data for future improvement of care. In recent years, the reporting of this data to various legislative task forces supplied policy makers with factual information as they evaluated the efficacy of programs and previous legislation. We believe that transparency will best serve the public and private sectors while, most importantly, serving our children and families with quality service options.

Regarding HB 5378:

The council is in support of HB 5378 and we would like to comment on two areas which we explicitly support.

1. We agree with the inclusion of a telehealth demonstration project to evaluate efficacy and to set reimbursement rates. The Council has evaluated several active pilot programs in telepsychiatry, including those funded by Value Options of Connecticut. To this point, the pilot programs have shown great utility in increasing access for patients to child psychiatrists. Additionally, the programs have improved coordination of care and facilitated consultation between primary care clinicians and child and adolescent psychiatrists. We believe that setting rates equivalent to face-to-face reimbursement would promote the use of this medium for healthcare delivery. We would like to specifically request that the definition of telemedicine not include audio use of telephone or facsimile.
2. We are in support of the extension of Medicaid insurance for up to one year after a family no longer meets criteria for this program. Many of the children and families that we serve utilize programs only offered if coverage is provided by HUSKY insurance. We want to encourage the families to not rely on state funding for care, but an abrupt change in payer often means an abrupt change in availability of services. As an example. A family who is originally covered by Medicaid is eligible for Intensive In-Home Child Psychiatry Services, if the employment or income status of the family changes such that they are not Medicaid eligible, the In-Home service ends. This disrupts treatment for the child and family. A month bridge of care will allow for adequate planning based on what is offered by the new insurance company.

Thank you for the opportunity to voice our support for these bills. Please contact our organization for further communication.

Testimony in Favor of HB 5371, 5372, 5373, 5378

From: Laine Taylor, DO of Connecticut Council of Child and Adolescent Psychiatry

To: the members of the program review and investigations committee

The greatest gap for access within this state is for the middle class families with private insurance. The accessibility to providers, programs, and adequate length of treatment hits our working class families hardest. Connecticut has a safety net for its poor in the form of HUSKY and the wealthy of this state can access fee for service treatment. This gap in care is relevant for all medical care, but impacts mental health care to a greater extent. The state of Connecticut is realizing the importance and wide reaching impact of mental health and access to mental health care for all individuals over the past year. Much of the effort to improve access has been for children and their families. This is seen in our state legislature's enactment of several laws including PA 13-3 and PA 13-178 which deal in the innovative efforts at delivering mental health screening and interventions to children. This is also seen through the Governor's administrative efforts and collaboration with the Office of the Health Care Advocate. As a Child and Adolescent Psychiatrist, representative of the Connecticut Council of Child and Adolescent Psychiatry, and a Connecticut resident, I am speak in support of HB 5371, 5372, 5373, and 5374.

Our statements in support of each bill are as follows:

Regarding HB 5371:

As any parent is aware, a child does not exist in a vacuum. The environment of a child includes school, peer interactions, and family. One of our most effective therapeutic interventions is the In-Home therapeutic service. This entails a licensed clinician entering the home to evaluate and address the behaviors of a child within the family structure. It provides the child, family, and clinician with a perspective unavailable through clinic visits. This intervention is not appropriate for all children, but is reserved for children with whom other interventions have been unsuccessful. Currently this is only available to family with HUSKY insurance or DCF voluntary services. The only current access to Intensive In-Home Child and Adolescent Psychiatric Services is through the use of state funding sources. It is the position of the Connecticut Council for Child and Adolescent Psychiatry that this level of care be available to all children within the state, including those with a private insurance payer. Reporting the use of state funding for in home services by those with private insurance will provide the state with information to determine further necessary steps to make this service accessible even within the access gap.

Regarding HB 5372:

The council also supports the development of a council in the administration to review policies and access to substance abuse care for all individuals. There is a deficit of services for

Line 22
Page 11

HB 5373

Connecticut Association of Addiction Professionals
 Susan C. Campion LADC, LMFT, President
 82 Morris Cove Road
 New Haven, CT 06512
 203.494.8148, <http://ctaddictionprofessionals.org>
 Public Hearing- March 4, 2013

Testimony on Raised Bill No. 5372- Access to Substance Abuse Treatment for Insured Youth and Young Adults: AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE ALCOHOL AND DRUG POLICY COUNCIL

To the Attention of the Committee on Legislative Program Review and Investigations:

The testimony is presented on behalf of the Connecticut Association of Addiction Professionals. The Connecticut Association of Addiction Professionals (CAAP) represents approximately 1800 credentialed addiction specialists; the majority of professionals hold licenses. It is the State Affiliate for the National Association of Alcohol and Drug Abuse Counselors. The Association is served by an all-volunteer Board of Directors, who advocate for public policy that empowers the State's workforce of addiction specialists, and most importantly, the substance abusing consumers whom the workforce serves. The licensed addiction specialist, LADC, is the statutorily identified professional provider of addiction services in Connecticut, who has met credentialing requirements, which encompass best practice standards of care in the treatment of addictions.

Today CAAP will present evidence, which will hopefully assist the Raised Bill 5372's charge to the Alcohol and Drug Policy Council's that the Council (3) develop and work to advance comprehensive strategies to improve access to substance abuse treatment for all persons living in the state; and (4) assess whether professional education programs for physicians, nurses and physician assistants in the state include (A) (i) sufficient training on behavioral health screening methods, and (ii) administering a brief intervention for substance abuse and referring patients for substance abuse treatment, and (B) encourage and provide assistance to those organizations offering such programs that do not provide such training so that they are able to do so.

The Association's findings reflect of the evidence in a 2004 SAMSHA Report
 A 2004 report from SAMSHA offered compelling evidence for the lack of education and experience in the treatment of addiction by PCPs and ancillary providers in a medical practice:

"A significant problem is the lack of education and training on substance use disorders for primary health care and other health and human services professionals. The National Center on Addictions and Substance Abuse (CASA) at Columbia University reported that 94 percent of primary care physicians and 40 percent of pediatricians, when presented with a person with a substance use disorder, failed to diagnose the problem properly (CASA, 2000). If similar studies were available for other health professionals (e.g., nurses, psychologists, pharmacists, social workers, dentists), the results would likely be similar."

"Curricula in most health education programs and professional schools either inadequately address substance use disorders or exclude discussion of them altogether." 2004 US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Report to Congress: Addictions Treatment Workforce Development [Section D, Education and Accreditation Priorities]. "

If CT persists in maintaining the current provider paradigm of doctors, nurses, social workers and or professional counselors, SA TX will be returning to the old workforce *Medical Model*, which was the standard 35- 40 years ago!

Past and current research has provided well-documented studies demonstrating the obstructions to access to healthcare due to the stigma associated with active substance users by providers from both the medical and behavioral health professions. The complexity of the disease of addiction brings multiple barriers to an effective and honest relationship between the provider and the substance user. The unintended consequences of these dynamics include the worsening of the patient's health status through impact of substances of choice on the pre-existing health and psychiatric co-morbidities, the patient's required medications, increased cessation of SUD treatment, and most importantly, a skewed provider-patient relationship plagued by mutual mistrust and respect.

As Connecticut moves into a new era of healthcare delivery with the implementation of the ACA [NB. Credential addiction specialists are required members of the ACA's *Workforce-Mental Health Professionals*] and the Advanced Medical Home, the credentialed addiction professional's highly specialized skills and expertise in providing evidence-based SA Treatment will be vitally important to ensure residents' successful health/behavioral health outcomes.

While CAAP supports the Raised Bill's charge to expand and enhance the fund of knowledge for our colleagues' in primary and behavioral health care, it is imperative that the Alcohol and Drug Policy Council recognize, and affirm CT's addiction specialists, as the *Lead Providers* in creating and implementing strategies for improved access to SA treatment for State residents, families, and significant others.

We offer the following "Friendly Amendment". CAAP recommends that the PRI Committee amends Raised Bill 5373: Section 1, (b) to add to the Alcohol & Drug Policy Council membership, *a Member of the CT Association of Addiction Professionals designated by the Association's Board of Directors.*

-4-

Testimony on Raised Bill 5373- AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE REPORTING OF CERTAIN DATA BY MANAGED CARE ORGANIZATIONS AND HEALTH INSURANCE COMPANIES TO THE INSURANCE DEPARTMENT.

It is a widely accepted fact in both CT's public and private behavioral health care, substance abuse treatment agencies, hospitals, and private practitioners that the HMOs and insurance companies' reimbursement rates by private and especially public payers (Medicaid) are disincentivizing qualified providers from accepting clients with SUD.

Addictions professionals and consumers from across CT regularly report to Board Members that insurance carriers' current practices create severe barriers to SA treatment. The barriers are all about money in the form of savings in an array of fiscal defense strategies!

These strategies include.

- Rationed utilization methods for course of treatment and length of stay to inpatient and outpatient treatment
- Questionable protocols for denial of claims.
- Network of providers, who may not possess the credentialing standards of educational and professional experience in the treatment of SUD.
- Low rates of reimbursement. As an example, the current schedule of Medicaid fee reimbursements discourage qualified and caring providers from accepting Medicaid patients. The current rate for a individual session is about \$45.
- Flawed access to SA treatment. Many Medicaid patients, who often present with the most complex medical and behavioral health disorders, receive marginal treatment, or encounter serious systemic barriers to care- lengthy waiting periods for healthcare appointments, language issues, complicated and uncoordinated referral processes to specialists, and patient stigmatization due to life-style and misinformation about the disease of Addiction.

CAAP supports a robust utilization review of provider and insurance carrier practices, as recommended by the Bill's tenets-Sections 7 & 8 . **The guiding principle of these sections are to reward not punish providers, whose performance outcomes are driven by treating a panel of patients, who are notable for its high numbers of individuals with serious, severity of health, psychiatric, and social issues. Otherwise, the present practice of major insurance carriers to "cherry pick" the healthiest patients by means of diverse and subtle mechanisms thus resulting in the exclusion of clinically challenged patients, and the Providers, who treat them, from their insurance plan will prevail.**

Another frankly dangerous and unfair perception is that Addiction is a second tier Disorder, which currently negatively impacts the delivery of SA treatment to state residents. **Addiction is a Primary Disease!**

"Alcohol and drug addiction cost American society \$193 billion annually, according to a 2011 White House Office of Drug Control Policy report.¹ In addition to the crime, violence, and loss of productivity associated with drug use, individuals living with a substance abuse disorder often have one or more physical health problems such as lung disease, hepatitis, HIV/AIDS, cardiovascular

-5-

disease, and cancer and mental disorders such as depression, anxiety, bipolar disorder, and schizophrenia.² In fact, research³ has indicated that persons with substance abuse disorders have:

Nine times greater risk of congestive heart failure.

12 times greater risk of liver cirrhosis.

12 times the risk of developing pneumonia.

When persons with addictions have co-occurring physical illnesses, they may require medical care that is not traditionally available in, or linked to, specialty substance abuse care. The high quality treatment needed by individuals with addictions requires a team of different professionals that includes both specialty substance abuse providers and primary care providers...

Other researchers reported that substance abuse disorders, depression, and medical co-morbidities relate to poor adherence to medications to treat type 2 diabetes.⁹ Yet, many individuals served in specialty substance abuse settings do not have a primary care provider".¹⁰

11. 2011 The Economic Impact of Illicit Drug Use on American Society. Washington D.C: U.S. Department of Justice."

In CT and many states, the denial of prompt and critical SA treatment based upon a blaming and negative paradigm that directs the access to services on a protocol of **Failure**, hence, the barriers of shame and stigma related to SUD are strengthened. It is not unusual for youth and young adults to be denied inpatient treatment until these consumers have "failed " at out-patient and intensive outpatient treatment. With this sector of the population presenting with the soaring rates of opioid addiction and over doses leading to death, this model is an egregious and barbaric system of care. Dr. Sharon Levy in her presentation at the 2014 Harvard Medical School's Symposium on Addictions (March 1, 2014) cited the following evidence of the prescription to heroin epidemic.

" In adolescents, recreational use of prescription painkillers accounted for 17.1% of all illicit drug use initiations beginning in 2009- More than Any Other drug than Marijuana. Dr. Levy further cited that 1 out of 8 High School Seniors reported using a prescription opioid for recreational/ non-medical use.

In Connecticut, we do not block necessary medical intervention and treatment from youth and young adults who have diabetes by withholding insulin medication until the young patient has a diabetic induced shock. CAAP recommends that **Raised Bill 5373 will result in a finding that a fair and equitable payment reimbursement policy will rest with a full and transparent implementation of the Mental Health and Substance Abuse Parity requirements.**

Our state has the 4th highest insurance costs in the nation. CT has a moral obligation to provide its residents, families, and partners impacted by the disease of addiction with insurance coverage that promotes swift access to evidence-based level of care, qualified specialists, and fiscal coverage and reimbursement policies which are equal to the complexities inherent to the disease. Let us always remember that Addiction is a treatable disorder, but if not treated with appropriate standards of practice, **Addiction is a terminal illness.**

In Connecticut, reimbursement of LADCs' services have been weakened in recent years. As previously noted, a trend in the state's behavioral health network of providers has perceived addiction professionals as "second class" behavioral health providers.

-6-

To remedy this matter, second the recommendation of CAAP's Vice- President, Bobbi Fox LADC in her formal correspondence.

CAAP strongly urges that the Committee develop language for inclusion in HB 5373 Section 1, (a), (7), (8) and (9) there is reference to the health care provider (of substance abuse services) as it pertains to insurance carrier approved network providers. In this instance we are referring to individuals not agencies. In the new language, the bill can contain a "friendly amendment" that specifically states that LADCs are the lead providers of choice for implementing substance abuse diagnosis and treatment in the state recommended panel of providers included in HMOs and insurance plans.

If the State chooses not to give full parity to licensed addiction specialists in its behavioral health provider, public and private payer network, the greatest risk will be to CT residents. Consumers, who seek substance abuse treatment, will be in jeopardy of losing access to evidence-based treatment and the highest standards of care for their addictions by the statutorily identified, behavioral health provider- the Licensed Alcohol & Drug Abuse Counselor.

The Connecticut Association of Addiction Professionals is prepared and eager to actively participate in all study & review, investigation, and oversight committees and venues, which are charged with the advancement and enhancement for the treatment of substance abuse in our state. CAAP stands ready to represent the workforce of addiction professionals through robust and rigorous advocacy on current and emerging best practice and value-driven initiatives for the prevention and intervention of the disease of addiction.

Many Thanks for your attention and Best Regards for your continued success in the 2014 General Assembly.

Susan Campion LADC, LMFT
President
Connecticut Association of Addiction Professionals
New Haven, CT

Line 23
Page 11

CT Association for Addiction Professionals
<http://ctaddictionprofessionals.org/>

March 2, 2014

CT General Assembly
 Program Review and Investigative Committee

Letter of Support for.

HB 5372 AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE ALCOHOL AND DRUG POLICY COUNCIL

HB 5373 AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE REPORTING OF CERTAIN DATA BY MANAGED CARE ORGANIZATIONS AND HEALTH INSURANCE COMPANIES TO THE INSURANCE DEPARTMENT

Dear Committee Members

First let me introduce myself; I am Barbara Fox the Vice President of CAAP, the CT Association for Addiction Professionals. Along with the other eight members of the all volunteer board for CAAP, we represent and advocate for addiction professionals in CT. In 2013 our organization was able to ensure statutory best practice standards for licensed alcohol and drug counselors (LADC) in CT*. This meant guaranteeing each addiction licensed professional has at least master's degree in behavioral health, an accompanying 360 hours in substance abuse specific training, worked at least 4000 hours under an appropriately credentialed addiction professional and passes a licensing exam. With this combination someone with an LADC has had education in both mental health/counseling AND addictions (co-occurring disorders)

In regards to **HB 5372** I think that a representative from our organization, CAAP, should be considered to *consult, or perhaps have an advisory seat, with The Alcohol and Drug Policy Council.* Currently we represent over 1800 addiction professionals in CT. With the implementation of the Affordable Care Act (ACA) the requirement for licensed credentialed addiction professionals being integrated into primary care settings will be necessary. Title V of the ACA identifies the substance abuse specialist as a member of its "mental health service professionals". Addiction treatment programs can expect increased demand for services from primary care settings because of the greater number of insured individuals with a new level of healthcare coverage. Who better to address the concerns of the council on such issues as education, training, access, supervision, diagnosis and treatment and other important areas of need than those that represent the addiction professional and know best what the current issues are facing our profession.

In regards to **HB 5373** in Section 1, (a), (7), (8) and (9) there is reference to the health care provider (of substance abuse services) as it pertains to insurance carrier approved network providers. In this instance I am referring to individuals not agencies. *I am hoping the bill can be amended so that LADCs (licensed alcohol and drug counselors) are the lead providers of choice for implementing substance abuse diagnosis and treatment to those who may be seeking treatment for a substance use disorder.* With this credential – LADC- it can be presumed that the provider has, as noted above in reference to **HB 5372**, obtained at least master's degree in behavioral health along with an additional 360 hours in substance abuse specific training, worked at least 4000 hours under an appropriately credentialed addiction professional and has passed a licensing exam. Unfortunately, for those with other behavioral health credentials we have no idea if they have *competency* in substance abuse counseling, diagnosis or treatment. The credential is the consumers, and in this case the insurance carriers, only way of knowing that treatment is being provided with someone educated and trained in both mental health and addictions specific counseling. In the case of other behavioral health care providers (LCSW, LMFT, LPC) a consumer and an insurance carrier cannot be assured that the provider has competency in diagnosing and treating addictions; that is why the credential in addiction counseling (LADC) is so important.

Finally, in all reviews, investigations or talks regarding the diagnosing or treatment of those with a possible substance use disorder I think it is imperative that a representative from the CT Association for Addiction Professionals be at the table. With our mission of representing and advocating for the addiction professional and promoting the advancement of the profession you can be assured that a representative will have information pertaining to the current workforce issues and be ready to address any concerns.

Sincerely,



Barbara K. Fox, MS, LADC
Vice President
CAAP – CT Association for Addiction Professionals
272 Redwood Rd.
Manchester, CT 06040
860-977-1448 (c)
bfox@manchestercc.edu



STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Testimony

Legislative Program Review and Investigations Committee

March 6, 2014

Raised H.B. No. 5373 AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE REPORTING OF CERTAIN DATA BY MANAGED CARE ORGANIZATIONS AND HEALTH INSURANCE COMPANIES TO THE INSURANCE DEPARTMENT.

Senator Kissel, Representative Mushinsky, and members of the Legislative Program Review and Investigations Committee, the Insurance Department appreciates the opportunity to provide testimony on raised **House Bill No. 5373: An Act Implementing the Recommendations of the Legislative Program Review and Investigations Committee Concerning the Reporting of Certain Data By Managed Care Organizations and Health Insurance Companies to the Insurance Department.** Generally, **H.B. 5373** would expand the reporting requirements of Managed Care Organizations (MCOs) to the Department of Insurance. The Insurance Department does not maintain a position on the underlying bill. However, should the bill move forward, the Department respectfully requests it does so with joint favorable substitute language that would strike the reference to the Office of the Health Care Advocate (OHA) in Sec. 1(b)(2) from LCO No. 1540.

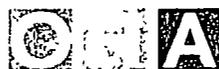
Section 1(b)(2) found in lines 137 & 138 of the bill would permit the OHA to review information deemed confidential by the Commissioner of Insurance. This provision if enacted would be unprecedented and not found anywhere in the insurance statutes. The only instances found in statute where the Commissioner may share information deemed confidential would be between regulators. While we acknowledge that OHA has statutory authority to establish a process to provide ongoing communication among mental health care providers, patients, state-wide and regional business organizations, managed care companies and other health insurers to assure: (1) Best practices in mental health treatment and recovery, (2) compliance with the provisions of sections 38a-476a, 38a-476b, 38a-488a and 38a-489; and (3) the relative costs and benefits of providing effective mental health care coverage to employees and their families, OHA's mandate does not reach regulatory status as it does not have enforcement authority. The General

Assembly has recognized that there can only be one regulator and to extend the privileges of a regulator to a non-regulator provides confusion and mixed messages. The Insurance Department can and does use confidential information to determine if an enforcement action is warranted. As has happened for the past 140 years, should a pattern of inappropriate conduct be uncovered, the Department's market conduct unit would investigate and such findings would be made public at the completion of the exam. Giving access to confidential information to a non-regulator could jeopardize an ongoing exam resulting in legal and remedial opportunity ramifications. Additionally, the relationship between a regulator and the regulated is a tenuous one fraught with challenges and reliant upon the regulator's ability to oversee without rushing to judgment, fairness in reviewing all facts and evidence before reaching conclusions, and the ability to provide due process. To add an additional factor to that environment could stymie the flow of information that currently exists. We are working with the OHA to obtain performance data they collect and we will certainly provide a means to exchange summary level data to assist the OHA in that office's statutory information gathering for trends.

The Insurance Department appreciates the opportunity to provide testimony to the Committee. Thank you for your consideration.

About the Connecticut Insurance Department: The mission of the Connecticut Insurance Department is to protect consumers through regulation of the industry, outreach, education and advocacy. The Department recovers an average of more than \$4 million yearly on behalf of consumers and regulates the industry by ensuring carriers adhere to state insurance laws and regulations and are financially solvent to pay claims. The Department's annual budget is funded through assessments from the insurance industry. Each year, the Department returns an average of \$100 million a year to the state General Fund in license fees, premium taxes, fines and other revenue sources to support various state programs, including childhood immunization.

www.ct.gov/cid
P O Box 816 Hartford, CT 06142-0816
An Equal Opportunity Employer



Office of the
Healthcare
Advocate
STATE OF CONNECTICUT

**Testimony of Victoria Veltri
State Healthcare Advocate
Before the Program Review and Investigations Committee
In support of HB 5373
March 4, 2014**

Good afternoon, Senator Kissel, Representative Mushinsky, Senator Fonfara, Representative Carpino, and members of the Program Review and Investigation Committee. For the record, I am Vicki Veltri, State Healthcare Advocate with the Office Healthcare Advocate ("OHA"). OHA is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

I would like to thank you for the opportunity to comment on HB 5373, An Act Implementing the Recommendations of the Legislative Program Review and Investigations Committee Concerning the Reporting of Certain Data By Managed Care Organization and Health Insurance Companies to the Insurance Department.

Expanding the data that insurers report to the Insurance Department ("CID") concerning member utilization of services for the treatment of substance use, co-occurring and mental health disorders will provide additional needed clarity to the issues concerning consumer access to treatment for these conditions. Detail about the frequency, duration, and level of care of member treatment for these conditions enhances our understanding of consumer's needs, as well as gaps in the ability of Connecticut's mental health system to meet those needs.

Seeking greater granularity in the utilization review and adverse determination process for these disorders, as well as the additional requirement that insurers report to CID the per member per month cost for treatment of substance use disorders, augments our ability to understand the true costs of mental health and substance use treatment, and better design systemic reforms to address these needs.

Improving consumer access to treatment will also be enhanced by the additional requirement that insurer's report on their mental health and substance disorder facility and provider network.

The Behavioral Health Taskforce created under PA 13-3 will release recommendations on the collection of relevant data from health plans. We urge you to align any data collection efforts with those of that task force to ensure consistency and efficiency in data reporting.

Thank you for providing me the opportunity to deliver OHA's testimony today. We look forward to continuing to collaborate and advocate for the consumers of Connecticut in this important matter. If you have any questions concerning my testimony, please feel free to contact me at victoria.veltrj@ct.gov.

**Connecticut House Bill 5373, An Act Implementing The Recommendations Of The
Legislative Program Review And Investigations Committee Concerning The Reporting Of
Certain Data By Managed Care Organizations And Health Insurance Companies To The
Insurance Department.**

**Statement of
America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, DC 20004**

**Connecticut Legislative Program Review and Investigations Committee Public Hearing
March 4, 2014**

America's Health Insurance Plans (AHIP) appreciates this opportunity to present our concerns on Connecticut House Bill 5373, An Act Implementing The Recommendations Of The Legislative Program Review And Investigations Committee Concerning The Reporting Of Certain Data By Managed Care Organizations And Health Insurance Companies To The Insurance Department.

AHIP is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of insurance products. We strongly endorse the concerns expressed by the Connecticut association of Health Plans in their testimony in opposition to House Bill 5373. The ongoing challenges of the implementation of the Affordable Care Act and the implementation of an All Payer Claims Database in Connecticut make the possibility of the additional data obligations extremely challenging for our member health plans.

In addition, if this bill is to move forward in some form, we believe that a technical correction is necessary.

Section 2(b) of House Bill 5373 addresses changes to the consumer report card requirements that only apply to managed care companies.

Section 2(c) currently is also so limited in its scope, but in deleting certain language and changing the applicability to "each health insurer that writes health insurance in this state", it incorrectly expands the reporting requirements as to mental health and substance abuse to non-medical, supplemental forms of health insurance. The reporting requirements of subsection 2(c) relate to the statutory mental condition mandates, Sec. 38a-488a. and Sec. 38a-514., which are limited to medical coverages ("Each individual/group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for the diagnosis and treatment of mental or nervous conditions"). These mandates do not apply to supplemental coverages such as accident only, disability income, dental, vision or prescription drug coverage. As such, they would have nothing to report.

We ask that you amend the bill and we believe that this can be corrected by specifically referencing those mandate sections in the applicability language at the beginning of amended Subsection 2 (c) as follows:

(c) [With respect to mental health services, the consumer report card shall include information or measures with respect to the percentage of enrollees receiving mental health services, utilization of mental health and chemical dependence services, inpatient and outpatient admissions, discharge rates and average lengths of stay] (1) On or before May first of each year, each health insurer that provides coverage in this state under Sec. 38a-488a. and Sec. 38a-514. writes health insurance shall submit to the commissioner;

Testimony in Favor of**Raised Bill No. 5373****AAC Implementing the Recommendations of the Legislative Program Review and Investigations Committee Concerning the Reporting of Certain Data by Managed Care Organizations and Health Insurance Companies to the Insurance Department****Testimony by****Jeffrey Walter****March 4, 2014**

I am writing in favor of Raised Bill 5373 which will improve accountability and transparency on the part of managed care companies with regard to the provision of adequate health care services to Connecticut citizens with mental and substance use disorders. I served as President and CEO of Rushford Center, one of the state's leading private, non-profit behavioral health providers, for 34 years and continue to co-chair the Connecticut Behavioral Health Partnership Oversight Council.

Mental and substance use disorders affect more than 200,000 Connecticut citizens each year. It is widely recognized that these disorders, when untreated, result in preventable co-morbidity, hospitalizations, and overall healthcare costs, not to mention unnecessary human suffering and premature death. Raised Bill 5373 requires managed care companies and health care insurers to submit detailed annual reports to the Insurance Department regarding their provider panels, expenditures, and denial/appeal experience – all related to the provision of behavioral health services. The bill is a result of several PRIC staff reports that describe the difficulties that insured individuals and families often encounter from their insurance companies when they attempt to gain access to behavioral health specialists and facilities in Connecticut.

This legislation might not be necessary were it not for the fact that behavioral health is treated differently by the insurance industry than virtually any other health care specialty. The State Office of the Health Care Advocate reports on denials and appeals on a quarterly basis for a variety of health conditions; care for psychiatric and substance use disorders is denied at a rate that far surpasses any other part of the health care system.

The adequacy of provider networks for behavioral health will also be addressed in this legislation. Again, there exists a lack of transparency by the insurance industry when it comes to real network adequacy. Too often, individuals contact a provider listed as in-network by their insurer, only to find that the provider is no longer enrolled or is not taking new patients. Insurers are not currently required

to take responsibility for the accuracy of their published network lists or to survey their providers to ascertain current availability as measured by acceptance of new patients and wait times for appointments.

While the proposed legislation, in and of itself, will not improve access to behavioral health care, it will shine a bright light on the current state of these important services in Connecticut and provide consumers with information they do not currently have. For this reason, I recommend approval of this bill.

Thank you.

Jeffrey Walter

Jeff.walter@hhchealth.org



Program Review and Investigations Committee

Public Hearing

Tuesday, March 4, 2014

Connecticut Association of Health Plans

Testimony in Opposition to

H.B. No. 5373 AA IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE REPORTING OF CERTAIN DATA BY MANAGED CARE ORGANIZATIONS AND HEALTH INSURANCE COMPANIES TO THE INSURANCE DEPARTMENT.

The Connecticut Association of Health Plans must respectfully opposes HB 5373. While we sincerely appreciate the immense desire for data in today's health care arena, the additional reporting requirements required by HB 5373 would be extremely strenuous and time and resource consuming.

The Association has the utmost respect for the analysis and professionalism of the Program Review & Investigation (PRI) staff and the health plans have worked cooperatively with them during the research phase of the study that gave rise to these recommendations as well as other studies over the past decade. The health carriers have always found PRI to be thoughtful and thorough in their approach even if we must "agree to disagree" with some of their recommendations

In this case, we would suggest that the Committee look to the All-Payer Claims Database (APCD) initiative currently underway for any new data needs instead of creating onerous new reporting functions. We can't lose sight that Connecticut, and the nation, are in the midst of an enormous implementation around the Affordable Care Act. While the Association is immensely proud of the work that's been done in Connecticut, it has been resource intensive and will remain so for the foreseeable future. At a time when carriers are doing their best to maximize efficiencies, it is difficult to support proposals that have the potential to duplicate existing efforts.

The health carriers have pledged to work with the APCD and are now in the process of developing, within the established policies and procedures, their first data submittal which is due this summer. While the APCD won't be "all things to all people" immediately, it is a central depository of data, from all payer sources, that we hope entities like PRI will look to in the future to find the data they seek.

With respect to some of the specific criteria in the bill, there are challenges which give us concern:

- There is no uniform definition of co-occurring disorder that corresponds for purposes of data collection. Carriers had problems responding to this question in PRI's request for data when the study was underway;
- There are limits to what information carriers *can* provide in terms of treatment for substance use disorders by level of care. This information is something that is self-reported by the providers themselves;
- The ability to accurately state the percentage of such providers accepting new clients is likewise subject to self-reporting by providers. Unfortunately, open practices are not something that can be tracked with accuracy – providers' schedules change from week to week and they may be accepting new patients on one day and not another. If providers notify carriers that their practices are full, the carrier will remove them from the on-line network directory. This measure is particularly problematic though the carriers understand the frustration that gives rise to the recommendation;
- Again, the provision which speaks to the age ranges treated by various providers is not a standard default and is subject to self-reporting. Depending on the needs of a member, some providers will treat various age ranges for one diagnosis, but not for another;
- While the carriers appreciate the recognition of provider capacity issues raised by some of the requested data items, carriers are limited in their ability to respond as such requests since it is not necessarily uniformly collected i.e., single case agreements;
- While carriers again understand the reasoning behind a request for county specific data, some frankly, do not currently have the capacity to run their data in that manner. Please keep in mind that carriers may have multiple data platforms for different segments within their business operations and such platforms do not necessarily operate in the same manner even within a given carrier. IT systems can inhibit even the best intentions to report accurate data and that is why the Association is supporting the efforts of the APCD ~ so that there is one certified repository where data is submitted in a uniform fashion.
- And finally, while the industry has a good working relationship with the current Office of the Health Care Advocate, it is not appropriate that uniform permission be granted to that office to view information marked "proprietary and confidential" by carriers. The Connecticut Department of Insurance is the industry's regulator and as such they are responsible for, and bound by, specific statutory obligations that are essential for a health regulatory environment. Again, the industry submits that such provisions provide for a duplication of authority which the Association respectfully opposes

Thank you for your consideration.