
Committee Meeting

of

SENATE LEGISLATIVE OVERSIGHT COMMITTEE

"The Committee will receive testimony from invited guests regarding the impact on patients and practitioners resulting from the lack of parity in health insurance coverage for mental health issues."

LOCATION: Committee Room 1
State House Annex
Trenton, New Jersey

DATE: July 18, 2013
10:00 a.m.

MEMBERS OF COMMITTEE PRESENT:

Senate Robert M. Gordon, Chair
Senator Barbara Buono, Vice Chair
Senator M. Teresa Ruiz



ALSO PRESENT:

Brian J. McCord
Office of Legislative Services
Committee Aide

Francisco Maldonado
Senate Majority
Committee Aide

Meeting Recorded and Transcribed by
The Office of Legislative Services, Public Information Office,
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey



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COMMITTEE NOTICE

TO: MEMBERS OF THE SENATE LEGISLATIVE OVERSIGHT COMMITTEE
FROM: SENATOR ROBERT M. GORDON, CHAIRMAN
SUBJECT: COMMITTEE MEETING - JULY 18, 2013

The public may address comments and questions to Michael R. Molimock, Committee Aide, or make bill status and scheduling inquiries to Sherri M. Hanlon, Secretary, at (609)847-3855, fax (609)292-0561, or e-mail: OLSAideSLO@njleg.org. Written and electronic comments, questions and testimony submitted to the committee by the public, as well as recordings and transcripts, if any, of oral testimony, are government records and will be available to the public upon request.

The Senate Legislative Oversight Committee will meet on Thursday, July 18, 2013 at 10:00 AM in Committee Room 1, 1st Floor, State House Annex, Trenton, New Jersey.

The committee will be receiving testimony from invited guests regarding the impact on patients and practitioners resulting from the lack of parity in health insurance coverage for mental health issues.

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SENATOR ROBERT M. GORDON (Chair): The Committee will come to order.

Good morning, everyone.

May we start with the roll call, please?

MR. McCORD (Committee Aide): Certainly.

Senator Kyrillos. (no response)

Senator Kean. (no response)

Senator Sarlo. (no response)

Senator Ruiz.

SENATOR RUIZ: Here.

MR. McCORD: Vice Chair Senator Buono. (no response)

Honorable Chairman.

SENATOR GORDON: Here.

Extra points to Senator Teresa Ruiz for your attendance today.

SENATOR RUIZ: Oh, I thought for being on time. (laughter)

SENATOR GORDON: Good morning, everyone.

I want to thank Senator Ruiz and all of our guests for being here today to address a very important subject.

The Legislative Oversight Committee is meeting today to examine the need for greater access to treatment for mental and behavioral health disorders; and more specifically, to better understand the barriers New Jersey residents face when they seek out these services.

These issues are complex, and I view this hearing as an opportunity to listen and better understand the nature of the problems. My hope is that we will conduct additional meetings in which we will discuss potential legislative remedies.

Mental health and substance abuse are very serious health concerns in this state. Recent press reports have described an epidemic of heroin addiction and a growing death toll from overdoses. In the wake of Hurricane Sandy and the shootings in Newtown, more attention has been focused on the need for expanded access to community mental health services.

We know that access to timely and comprehensive care -- whether for physical or mental conditions -- has a direct impact on quality of life. Unfortunately, a very real disparity exists between one's ability to access traditional health care as opposed to mental health care. The effects of this disparity, as we will hear today, are far too often catastrophic for individuals and their families.

Significant strides have been made in reducing the disparities in insurance coverage. Federal laws enacted in 1996 mandate parity in annual and aggregate lifetime limits, and the Federal Parity legislation of 2008 requires group health plans and health insurance issuers to ensure that the terms of coverage for mental health disorders are no more restrictive than those applicable in medical and surgical cases.

However, these laws still do not require the coverage of mental health conditions and substance abuse treatment. And the multiple exemptions and carve-outs found in various types of plans mean that many of the insured still do not have coverage for mental health conditions. A recent GAO report indicates that health insurance plans have actually increased the number of exclusions for mental health and addiction treatment since the Federal Parity law was enacted in 2008.

Here in New Jersey, our laws only require that a health insurance contract provide coverage for biologically based mental illness. The State and School Employee health benefit plans also provide coverage for nonbiologically based mental illness, but they do impose limits on utilization.

It should be noted that Senator Vitale has sponsored legislation to greatly expand coverage for mental health and nervous disorders, regardless of whether the disease is biologically based. We are very hopeful that the Governor will sign this bill soon. Still, the bill only applies to the State and School Employee benefit plans. It would not affect private health insurance providers.

The bottom line is that the lack of an overarching requirement for coverage of mental health and substance abuse treatment, and the many exemptions provided in Federal and State law, create a two-tiered system that is fundamentally unequal.

We will hear today from a number of individuals, their families, and providers who are terribly frustrated with their inability to access treatment or receive adequate reimbursement for services, even when these services are supposedly covered by the insurer. Anecdotal evidence suggests that managed care organizations in particular have habitually delayed, denied, and refused to cover treatment for needed services or have decreased the treatment protocols that are deemed necessary by the provider. The adequacy of the network of mental health providers has also been the subject of intense scrutiny.

The reality is that many networks are illusory. In far too many cases, when a patient tries to access the provider network, they encounter

doctors who are no longer accepting new patients, or inaccurate contact information. The compounding effect of these hurdles is significantly reduced or ineffective treatment which could lead to devastating consequences.

In light of the impending implementation of the Affordable Care Act and the Medicaid expansion, I believe it is important for us to address these issues as soon as possible. It is my hope that today's hearing will help us better understand the scope of the problems and point us to the legislative remedies.

With that, I'd like to call our first witness, who is Wayne Dibofsky of the Health Coverage Advocates.

Wayne, would you please make your presentation?

WAYNE DIBOFSKY: Thank you, Mr. Chairman.

Thank you for the hearing.

Senator Buono, Senator Ruiz, thank you for being here.

And thanks to your staff for all their due diligence on this issue.

Thomas Jefferson once said, "The care of human life and happiness is the first and only legitimate objective of good government." We're here today to show you that the system needs retrofitting.

I have given to you and the members of the Committee an expert analysis of a tri-state report on mental and substance abuse concerns that have plagued the State of New Jersey and surrounding states for a number of years. Those expert witnesses, unfortunately, were not able to attend today, so I'm going to give it my best shot on their behalf.

As you indicated, Senator, we're here to shine light on those who have suffered too long in the dark and in silence. We're here because

of concerns, illnesses, and tragedies -- all which have occurred in the State of New Jersey with people who have health insurance. And they have suffered in silence because their illnesses, of themselves or their families, are shame-based.

Today you will hear from that cross section, as you indicated, Senator -- people who, either themselves, or as caregivers, have found members of their families who have fallen between the cracks based on the good intentions of law, bad treatment policies, and a serious effort to control healthcare costs in the State of New Jersey; but at what consequences.

Untreated behavioral health, drug and substance addiction, and mental health waits for no one. It destroys individuals, it destroys their families, their neighborhoods, and most importantly it robs society of an economic base. These disorders today impact 1 out of every 10 adults in the State of New Jersey, 1 out of every 4 families, and 70 percent of our current workforce. And what is most interesting and debilitating is that these people who suffer in silence with shame-based illnesses -- almost 90 percent of them have health insurance; health insurance which they are paying more for each day and getting less in a dollar reimbursement in return. They have an insurance level and get caught in a catch-22 because of an innocuous term called *medical necessity*, which is handled by the managed care providers as a code word to provide a diminution of benefits for those who are expecting more and getting less. They erode each and every day. And what happens is, you then leave the State of New Jersey, through Charity Care and other taxpayers, to pay for the shortfall that is

already being paid in insurance premiums by the families. So it's a double-edged sword -- paying more, getting less, transferring it to society.

As you indicated, Senator Gordon, the system needs a retrofitting. Because when I look at my insurance brochure and I look at my benefits design, I think I'm okay until I make that first initial phone call when I am facing tragedy, uncertainty, and unrest. Because when I'm in a crisis I need help, either for myself directly or for my family. I don't need the added stress, and strain, and the dance of bureaucratic push back.

But that's what happens in most cases dealing with the public entities today. All too often here is what happens: A patient makes an essential call for a loved one, and the call is essentially bounced off. The attendee on the other end of the line is not a certified person or, in many cases, not even sensitive. And I go through this rabbit hole where constant calls, constant paperwork, constant denials occur over and over again. I have enough on my plate to take care of myself or my loved ones. I need not to do battle with a managed care provider. But that is the situation I now find myself in.

We're impacting real people with real families, many of whom you will hear the stories from today far better than I can describe. What will become very clear to the panel today is the evidenced-based treatments cannot be limited to a few days; no more so than if you asked me-- As a doctor, you gave me an antibiotic to take for 12 days to rid myself of the virus in my system -- that you're only going to give me the medication for two days; but at the end I will still feel better. It's not going to work. We're shortchanging our public, we're shortchanging our citizens, and we're

shortchanging everyone who is expecting more, not less, from public services and good government.

So I thank you for the opportunity. I hope you'll take the opportunity to read the materials I provided by Deb Beck and Greg Heller. And I know that the testimony today will be riveting, and you'll have good questions to ask them.

Thank you again, Mr. Chairman.

SENATOR GORDON: Thank you, Mr. Dibofsky.

Any members of the Committee have any questions? (no response)

Thank you very much.

We will next hear from Mary Ditri -- I hope I have that right -- and Dr. Joe Miller, from the New Jersey Hospital Association.

MARY A. DITRI: Good morning.

SENATOR GORDON: Good morning.

MS. DITRI: My name is Mary Ditri. I'm the Director of Professional Practice at the New Jersey Hospital Association.

Thank you, Mr. Chairman, for the opportunity to speak this morning.

Before I turn things over to my colleague Dr. Miller, I just wanted to provide some data to the Committee, based on an analysis that NJHA has conducted and work that we've been doing over the past seven years in this regard, to help paint a picture of the volume for this need throughout the state.

We took a look at two patient populations: First, the population of individuals who come to the emergency departments seeking

behavioral health and addiction services. Those individuals are presenting -- and do not meet the criteria for an in-patient admission. They're discharged back out into the community.

Over the last seven years we've seen a steady uptick in volume. There have been no decreases on any age group, any county, any hospital, or any payer in that regard for the last seven years. Between 2011 and the preliminary data for 2012, we've seen about a 16.5 percent increase in that number. In 2012, we are looking at more than 520,000 individuals who meet that criteria. So more than 500,000 are coming into the hospital emergency departments. They are not meeting the criteria for an in-patient admission and are being discharged back to their homes, back out into the community. Compared to our total emergency department visits -- we're only seeing about a 4.5 percent increase in total visits between 2011 and 2012, so the difference is significant.

When we took a look at the payer mix for that population, the number one category -- the highest volume is really the Charity Care and uninsured envelope of folks, followed by Medicare HMO and fee-for-service, and third is the commercial HMOs, and fourth is the Medicaid HMO and fee-for-service. Those are broad categories, but we can drill down on that if need be for folks to look into that a little bit further.

The second category of individuals that we looked at are those folks who come into the emergency department, are treated -- examined and treated -- and they do meet the criteria for an in-patient admission. So we looked at primary and secondary diagnosis for behavioral health or a substance abuse need. And on the primary field we saw about 6.5, close to 7 percent of our total in-patient population are for individuals in need of

behavioral health or substance abuse services. For those with a secondary diagnosis, we're looking at anywhere from 30 to 50 percent, depending on the hospital and depending on the county you're looking at. So in statewide aggregate numbers, we're looking at about 30 percent of individuals. And on the payer side -- Charity Care and uninsured again the largest pocket. But on the secondary it comes as no surprise that it's the Medicare HMO and fee-for-service category for that group.

On the in-patient side, we saw less of a shift from 2011 to 2012, but again there was an increase -- a slight increase in all categories. We were able to slice the data according to hospital, according to county. We're more than happy to provide the full report to the Committee after today so that you can have it to take a look at. But we used that data to form some work at the local level to help providers to start to move toward creative solutions to address the access-to-care issue without looking for formal remedies. We know that the providers need to deliver care. And we started looking at the national level to see what is working nationally.

Dr. Miller is going to speak to the work that providers are doing. But on a larger scale, we're more than happy to provide that analysis as well on the Federal side.

SENATOR GORDON: Before we move on to Dr. Miller, just a couple of questions that occurred to me. What do you think accounts for this uptick in ER volume? Is it because of substance abuse issues, or psychotic episodes and more traditional mental health illnesses -- if I can call them that?

MS. DITRI: Well, I think when you look at the state, it really depends on the area that you look at. It depends on the hospitals, it

depends on the community, it depends on the county, and it varies from county to county. We can take the codes that we look at and we can drill it down a little bit further to help hospitals really identify their high volume, problem prone areas. I think that Dr. Miller is also going to speak to that a little bit and how they work at a local level to identify -- when we look at the secondary diagnosis -- what is that all about. When someone comes in with acute pancreatitis, is it acute pancreatitis, or is the underlying condition a substance abuse issue? So it's really a complex picture.

I think on the uptick -- to answer the uptick question -- some assumptions can be made from the data. When we look at the treat-and-release population, I think the conclusion that many come to when looking at that is the resource issue, making an assumption that if there were opportunities for integrated care in the community, or better medication management, perhaps, in the community, these folks would not need to present to the hospital emergency departments.

SENATOR GORDON: Do we know whether the people who are showing up to the ER have tried to obtain treatment somewhere else?

MS. DITRI: If you wouldn't mind, if I could punt to my colleague for that because he has the direct experience.

SENATOR GORDON: Dr. Miller, why don't you proceed then?

JOSEPH MILLER, Ph.D.: Sure, thank you.

Senator, thank you for the invitation, the opportunity to speak, and to appear before this Committee.

In your opening comments you hit it right on the head. You said this is a very complex issue. This is an enormously complex issue.

What I wanted to offer to you today is kind of a boots-on-the-ground testimony. My current role is Chief Operating Officer for Riverview Medical Center, which is a 400-bed community hospital located in Red Bank, New Jersey, and part of the Meridian Health System, which is five hospitals up and down the New Jersey coastline.

My background, you should know too, is my doctorate is a Ph.D. in clinical social work. Next year I will be celebrating my 30th year as a clinical social worker, and I've had experience ranging from direct care clinical care provision, to, right now, I'm a hospital executive, and everything in between. So I've actually designed networks of care for health systems. So I come with a fairly broad perspective.

But today I want to talk about what it's like in hospitals. On any given day I can walk into one of the emergency departments at the five Meridian hospitals and there will be 6, 12, 16, 24 behavioral health patients. You're asking questions about, "Who is presenting at hospitals these days?" It could be a patient who has a co-morbid substance abuse issue as well as an underlying psychiatric issue. It could be a child or adolescent; someone who drew a picture in school, got somebody very concerned, and they had to come and be seen at a crisis unit or an emergency room because of the concern. It could be a developmentally disabled individual who has psychiatric behavioral issues who ends up in an emergency department.

And I kind of pointed out those three categories because I just named our three most challenging patient categories within the general psychiatric population who utilize hospital services. And I do want to tell you, an emergency department in a hospital is a terrible place to be if you

have a psychiatric issue. It's noisy, the lights are on 24-7, and it is an overstimulating environment. It could be terrifying for a psychiatric patient who is hallucinating. I will tell you that as a clinician, I will tell you that as a hospital leader.

The reasons that people are coming to our emergency departments are myriad. It could be things like basic needs like housing, food, employment, access to care. If you can't get care in the community where we would hope it would happen, and you start to decompensate, you're heading for the emergency room. That's where you should be headed. But, again, it's not the best place to receive service. Some people show up because they have psychiatric conditions that are related to not having their basic other medical needs taken care of, that could be compounded -- or compound psychiatric issues.

So we ask this question all the time: What's the answer? Because those groups that I talked to you about -- if we have-- If I walk in on a Monday morning to one of our ERs, very often I will see psychiatric patients who may have been involuntarily committed and are waiting 24, 48, 72 hours plus to access a bed in the system -- one of the short-term care facility beds. And I believe there are now over 400 statewide. And we hit that gridlock -- we call it -- very often where, particularly on a weekend, there are not enough beds for the patients who need them. So what we then start looking at is what is available in the community? Why are people coming to the emergency departments? And Mary mentioned it. Are there enough community resources out there? And that's a big question. Is there enough basic housing? New Jersey is a very expensive state to live in. SROs are on the decline. Our patients who struggle at

times with employment don't always have access to housing and basic needs. That compounds things.

So I think our big challenge is to focus on delivering care in the community. And I know that's-- It's been a nice push in New Jersey to try to establish those resources, but it's an ongoing push. We need to deliver care where the patient is, not get them to an emergency room and then try to figure out where they need to be -- whether it's an in-patient or outpatient setting.

I think some opportunities that we have are to encourage the development of integrated behavioral health care with primary medical care -- whether it's enhancing federally qualified healthcare organizations; whether it's through the Affordable Care Act, as the accountable care organizations are forming -- to have that as part of the clinical continuum where you have integrated behavioral health and medical care.

In the white paper that Mary has submitted, which was developed by the Hospital Association, there are opportunities for the use of technology in the form of telepsychiatry, for instance, where a psychiatrist can remotely assess a patient. It sounds kind of scary, sounds kind of crazy, but it's a way to get the resource to the patient whether they're in a hospital emergency room or out in the community. It should be considered. There has been some success with models like that, particularly given the shortage of psychiatrists in the community who are available to treat patients.

Crisis units in community hospitals and in tertiary care hospitals are a must. I always recommend that they not be in the general emergency department setting, again for all of the reasons I shared. It

needs to be a place where patients can be stabilized while we're trying to get them to the next level of care where they belong.

And the other piece is-- I've been part of the New Jersey behavioral health system, again, coming up on 30 years. One thing I'm thrilled with, quite honestly, is that when I started my career in 1983-1984 there were still a lot of patients who were basically spending their lifetime in the back wards of state psychiatric hospitals. We made a nice move in terms of getting the patients out and establishing community resources. But I think -- again, to use your word *complex* -- now we've come way over here, and I think we need some middle ground. An average length of stay for a psychiatric patient in an in-patient bed is probably three to five days maximum, and then we have to figure out what is the next step. And that's where the community care coordination comes in. There are models out there for what are called *intermediate beds*, where a patient can spend an additional 30 days or 60 days in an in-patient setting in the community that is not a state psychiatric hospital. I think that needs to be explored.

So in kind of wrapping up my comments, I think there is a lot of opportunity here, and I do think it's going to take a very coordinated effort on the part of providers, on the part of legislators, government, on the part of payers to all get to the table and figure out something that makes sense, is rational, and that everybody can get behind. This is an exceptionally complex issue, and I'm thrilled that we're addressing it. I really am. My hope is that I'm going to walk through one of our emergency departments one morning and there is going to be nobody waiting for a bed because we're able to take care of their needs in the community.

Thanks.

SENATOR GORDON: Thank you, Dr. Miller.

One of the points that you made that really struck me is the high percentage of Charity Care patients coming through the ERs. That's a pretty clear indication that whatever savings might be achieved by a managed care organization, for example, the costs are being shifted to the taxpayer. And this is a cost to society that we need to address somewhere.

I've got a question about just what some of our options are. And I don't know whether you're the best source of this information, but let me give it a try. My understanding is that because of Federal preemptions related to ERISA -- which govern the terms of commercial plans -- that our opportunity to have an impact is really limited to the Medicaid population and those people who are participants in the State and the School Employee health benefit plans. One: Is that understanding correct? And what thoughts do you have on some of the things that we as a State Legislature can do to try to improve this situation, whether it's trying to get more resources into the community or other things? I'd be interested in your thoughts.

DR. MILLER: Sure.

Again, my thoughts are: The more resources we can develop in the community, the better off we're going to be. Again, New Jersey is a tough state to develop community resources in. Let's face it, it's a small state. It's expensive to live. And we have a lot of, "Not in my backyard," when we try to locate community resources out there. So it is a challenge.

I think what we can do, though, is first create the vision with all the partners at the table and find-- You're talking about managed care companies all the time. What is the incentive for managed care companies?

They're a business. There has to be a point at which they're saying, "It makes really good sense to us to develop and get behind this kind of a community-based model," whatever that is.

To your point about Charity Care, right now our behavioral health population that we're seeing in the hospitals-- There's probably about 33 percent Charity Care. That's what we're experiencing coming in. Another probably 45 percent are Medicare and Medicaid, and the rest are commercial insurance.

Again, I tend to be one of these hopeful people. I really do believe that if you get the right people around the table and can design a rational plan that makes sense to everyone and there are incentives, you can make it work.

MS. DITRI: If I could just add also to Dr. Miller's point about bringing the right people to the table, NJHA's behavioral health constituency is a very active group, and we've been quite successful in working with -- when there are *pocket issues*, I like to call them, that we need to address with a payer or a group -- we've been very successful in being able to bring those folks to the table and working collaboratively toward change. But I think that if we use that model and that collaborative approach, we might be able to move forward a little bit faster.

SENATOR GORDON: Any questions from the Committee?

(no response)

Thank you very much.

DR. MILLER: Thank you.

MS. DITRI: Thank you.

SENATOR GORDON: We will next hear from a panel of individuals who have -- I believe have some experience in the system. I'd like to call up Lynne Clements, Laura Spector, and Pat Woods.

Please proceed.

LYNNE CLEMENTS: Hi, my name is Lynne Clements. I'm a teacher in the Middletown School system. And I want to thank you for the opportunity today to come and speak with you.

I am speaking on behalf of my son, who I'll refer to as JC to protect his privacy.

In 2007, my son graduated from the Family Foundation 12-Step boarding school. At the time he was 19.

I'm sorry if I get emotional.

SENATOR GORDON: Take your time.

MS. CLEMENTS: He was diagnosed with ADHD, oppositional defiance disorder, adjustment disorder with mixed disturbances of emotional conduct, anxiety. And he was addicted to cannabis, which is pot, and alcohol. The \$72,000 bill for the boarding school was well worth it, so we thought. He graduated with honors and had his high school diploma.

I'd like to share some of his graduation speech with you that he wrote on that day.

"I can't really remember a time in my life where I thought I would be given a new beginning and a new opportunity to live my life the way it should have been lived 19 years ago. I started to live my life expecting there not to be a next day -- or at least I treated my family, friends, and myself as if there wouldn't be one. Drugs, alcohol, sex, and

violence have been the only symptom of my problem; but I based my next breath of air on the next joint, bottle, and girl I could get my hands on. The insanity and unbearable pain that I brought with me every step that I took grew worse and worse, and I eventually became a monster who didn't care about anything but myself."

He goes on to say, "There was a time in my life a few years ago I can remember sitting at my kitchen table with a few friends while watching my baby brother. As I walked out the door onto the deck, my brother tugged onto my shirt and asked if he could get high with me and my friends. He was only 4.

"Relapsing would mean that I will yet again become the same monster that destroyed the relationship with my family and the opportunity for me to live my life to its fullest."

He goes on in his letter to thank my family for our support.

JC, as I will refer to him, has graduated from the school 6 years ago. Today, my son is a heroin addict, no longer a pot addict. He has lived in 14 rehabs, usually on a weekly and, many times, on a day-to-day basis as his eligibility to stay was determined by our managed health care. When managed health care denied his coverage, JC admitted himself into three different hospitals, as these people just said, stating that he had suicidal thoughts, so that he could detox and have a bed to sleep.

When the insurance payments stopped, JC lived in many halfway houses. They each required a large, nonrefundable deposit which we would need to be paid and required \$175 to \$225 per week on his part. JC would always find a job but would always be in debt. This scenario played out every time.

Frustrated, JC would try to move out to a place he could afford, but always relapsing shortly after. He also attended several outpatient rehabs and saw two different psychiatrists and four different therapists. The worst times for us are highlighted in my packet here in yellow. These were the times when we did not know where he was. Rehabs wouldn't take him because the insurance didn't cover, and so he lived wherever he could -- sometimes on the beach, homeless shelters, train stations, church basements, crack houses in Newark; and, as we learned later, in our shed. During these time periods he blacked out many times. He broke his jaw, needed knee surgery. And we found out later that he had gotten high prior to the knee surgery and almost died. He totaled his car, and the list goes on.

Addiction is a family disease. The stress that it's put on my family is devastating. Beginning April 2009 to present, we have attended approximately 130 hours of therapy. We started therapy when our youngest son, who I mentioned in JC's letter, was 9. We did so because my youngest son stated that he wanted to kill himself in school. It will take years before we recover from the financial burden this has placed on us, some of which is outlined in my timeline. The time taken away from our children, forcing my youngest son to miss his childhood, can never be replaced.

Today, JC is living in a new treatment center in Florida. We aren't sure how long the insurance will cover, but are grateful to sleep at night.

In September, JC will be 26, which means he will no longer be covered by my insurance. Recently, I called our managed healthcare

company to inquire about their extended coverage. The first agent told me that I should let go of my son, that this was his choice, and that Charity Care would always cover him. The second person I spoke to told me that he needed to be mentally retarded to be covered. When I asked exactly what that meant, since it was a very broad, outdated term, she couldn't tell me, but she did say to send all his diagnosis codes and they would determine his necessity and eligibility.

These responses didn't really surprise me, especially after receiving a letter from them in December 2012, which stated, "The member no longer has significant potential for improvement with any standard medical treatment. The member's psychiatric symptoms have become chronic, and the reported symptoms, with limited insight and judgement, require treatment in a long-term care facility. Therefore, our managed health care is unable to authorize your request for admission to in-patient mental health treatment. Member may choose intensive outpatient mental health treatment, but authorization must be obtained."

Had our managed healthcare company allowed a longer stay at one of our rehabs, JC's chances of recovery could have been far better. As a result, we could have avoided many of the hardships that we have been faced with. Managed health care must tailor their coverage to each individual. JC was detoxed, given a little therapy, then thrown out because he was cured. No one ever addressed the real causes of his addiction.

That's out story. I'm ready for any questions.

SENATOR GORDON: Thank you.

MS. CLEMENTS: You're welcome.

SENATOR GORDON: Thank you very much for sharing that with us.

Either Pat Woods or Ms. Spector.

PAT WOODS: Good morning.

My name is Pat Woods. I have been with the healthcare system since 1969 when I started teaching in the State of New Jersey.

One of the most important points I must state is that I am a very private person. Managed care refused to pay for two sessions per week and wanted confidential information. I gave permission to my therapist to give that information to the psychiatrist on March 18, 2009. At that time, the psychiatrist was satisfied with the information given and approved the two sessions per week for up to 6 months; and then from 6 months to 12 months wean it down to one session per week. Six weeks later managed care required another review to approve sessions, even though information was given to their psychiatrist six weeks earlier. Managed care denied additional sessions, and I appealed their decision for the lack of information.

Due to extenuating circumstances -- my house fire in July of 2009 -- my therapist applied for more session. A psychiatric review with a Rhode Island state-certified psychiatrist resulted in his denial of two sessions per week. When asked by my therapist what would justify two sessions per week, his reply was, "A death of a child."

We appealed his decision before managed care. During the telephone appeal, the moderator called me by Ms. Woods. I was under the impression this was going to be a confidential hearing. Some of the errors the second psychiatrist stated in his report were concerning me. The

progress in looking forward -- which was not true -- better functioning in community, less agitated, depressive symptoms improving, and no access to lethal weapons. My therapist did not say any of the above items since I was deteriorating and less functional. Therapists questioned why the first psychiatrist's review was not followed -- the two sessions per week and weaning down to one session per week within 6 to 12 months.

I thought if I gave some of my confidential information, the appeal board might be more understanding of the problems I was going through. In April of 2002 I had breast cancer, and I am a survivor. I was diagnosed with diabetes in 10/2001, I had rotator cuff surgery in February of 2003, I had a liver biopsy and diagnosed with PBC in September of '02, and another liver biopsy in February of 2010. I had my two knees and my one hip replacement, I've had a thyroid biopsy because I have four nodules, I was displaced from my home due to the fire. My confidential information did not help the outcome of the review. The review was denied for two sessions per week. I continued to pay, myself, for the second session until I reached the golden age of 65 and went on Medicare. And I might be a little sarcastic about that, but I think going on Medicare is the magic sign-off. It helps a lot. So, everybody, hurry up and get old. (laughter)

I appealed to the State Health Benefits Commission. Three weeks before my hearing, the insurance paid for all the claims for the second visit to my therapist. The Benefits Commission refused to permit me to appear at the hearing and inform them of how the managed care company's behavior was. It's bad enough that I had to be reimbursed for an out-of-network therapist, but I had to wait one year for the payment of the

second session. If I don't need to get approval from my general practitioner or other doctors, why do I have to get permission to see a therapist?

Now, I have important points that have to be considered. To me, they're very important. The first thing is: My confidentiality was treated with the utmost disrespect. It is very sad that the State Health Plan is spending so much money on insurance companies and not health care. Insurance companies do not provide treatment. Their goal is to limit my benefit and maximize their profits. What would be more cost-effective and better for the patient: two sessions per week seeing a therapist, or admitting myself into an in-patient psychiatric hospital?

Mental health treatment is an arduous task usually undertaken as a last resort for the people who are most vulnerable and least able to advocate for themselves, yet managed care is exploiting this by requiring subscribers to meet the medically necessary and appropriate level of care -- if I hear that one more time I think my hair is going to go natural -- (laughter) I'm sorry, this is very serious and I don't mean to be making jokes, but this is my way of coping -- criteria in order to qualify for reimbursement. This will eliminate many subscribers from seeking the necessary help they need due to the issue of compromised confidentiality.

The success of mental health treatment is based on the therapeutic alliance which includes trust and confidentiality, except in certain dire situations such as harm to self or others. Mental health is not medical health and should not be treated with the same one-size-fits-all mentality. Many studies have shown that there is a link to increased medical procedures and expenses that could have been prevented with medical (*sic*) health treatment. The intent of the parity law was to open

access to mental health treatment where in the past it had been arbitrarily limited. Now it appears that just the opposite is occurring with the systematic erosion of access to mental health benefits, thus making mental health treatment available only to the rich. Cookie-cutter treatment does not work for mental health treatment. Medical necessity and appropriate level of care is a way to restrict treatment to crisis intervention while blocking access to preventative care. Crisis therapy is not conducive to good mental and/or physical health. It is important that the laws protect access to mental health treatment and do not give a club to the insurance company to use against the insured to limit and deny access to mental health treatment. The Social Workers law was made to protect the client and their confidentiality. Just as the United States Supreme Court upheld the confidentiality of a social work therapeutic session in the *Jaffee v. Redmond* case, so does the Social Workers law protect the clients' confidentiality.

I hope you understand my position. Thank you for listening.

SENATOR GORDON: Thank you very much.

Before we hear from Ms. Spector, Senator Ruiz, did you have--

SENATOR RUIZ: No, I will wait until the last.

SENATOR GORDON: Okay.

Ms. Spector.

L A U R A J. S P E C T O R: Good morning, and thank you for allowing me to be here.

My name is Laura Spector. I was a teacher with the Bridgewater Raritan School District for 34 years and am currently retired.

It is an honor for me to testify about a passion of mine, mental health care. It is because of therapy I am able to speak to you today.

My voice represents a large, silent group of individuals seeking to better their lives and their livelihoods. My personal diagnosis is anxiety and clinical depression from a background of abuse. When this condition started to affect my career -- which I wanted desperately -- I sought help, and my doctor was out-of-network. Problems arose when managed care took over the mental health care from BlueCross and BlueShield. Because my doctor was out-of-network, it became my responsibility to submit all claims, take care of all paperwork, and deal with the insurance company. I feel that the repercussions of these additional stresses ended up costing me more time and money because of these additional sessions. They played a part in prolonging my treatment, being counterproductive to the process.

I'd like to share some of the problems, but not all the negative interactions. No written procedures were provided. Even upon repeated requests and verbal agreements from whatever representative I spoke with to please send me the process, the procedures, nothing ever materialized. This went on for several years. Changes of procedures with no prior notification -- even my credit card companies let me know when things are going to change. This led to stalls, denials, resubmissions if they were applicable and allowable, and the appeals process -- one that took three to four months to get straightened out with a large, out-of-pocket cost to me piling up.

Some other changes: There was a grace period -- an overlap period for treatment request forms so that the process of treatment could continue in a smooth and continuous fashion. It was ended without my

doctor or I knowing, so I had denials which lead to delays, stalls, and late payments.

Lowering allowed authorizations from 12 to 6 sessions: If you're doing group therapy -- as I was once a week, along with my individual therapy -- those 6 sessions now were split. So now you have three and three, which is approximately three weeks -- not even a complete month. And by the end of that second week, a treatment request form has to be going in, in order to have the authorization for the continuing treatment, which is an enormous amount of paperwork. And if it's not on time, then you have stalls, delays, and denials.

Suggesting that I consider another doctor went on for quite a while, possibly one in-network, which I resented. I had been seeing this therapist for quite a while and it was working. Why should I change to somebody they would like me to have?

And now my favorite: "We have no record of receiving that claim." For a while, this took place every three or four months, causing delays and denials -- additional costs to me. I started sending claims registered/return receipt every month. I became close friends with Dee Lewis (phonetic spelling) and the postal workers who welcomed me by name. This was an additional cost also.

And finally, if there was an issue and more than one call was necessary, different customer service reps would give different responses. More calls, more inconsistencies, and more stress.

Like the students I taught, mental health growth is a journey. It begins with readiness, which is different for each person. Delays, phone calls, backtracking, standing up for oneself all are stressful in a regular

world, but especially in extremely sensitive situations. Better communication, policies, and care in the handling of clients is essential and ultimately productive for all.

Thank you.

SENATOR GORDON: Thank you very much.

I thank you, all three, for sharing these very personal experiences and really putting some flesh to these problems that we're trying to address today.

I have just a question for Ms. Spector. In all of these interactions with the managed care company, was there anyone out in the community or in government who was available to help you in even the paperwork process or in interacting with the managed care companies? And if there were, for example, let's say a State advocate who could act as an intermediary for you, would you have found that helpful? Would that have worked?

MS. SPECTOR: I can honestly say I'm not sure. Part of the problem that I was learning to deal with was recognizing networks, and support systems, and such. They were not-- When you come from my kind of background, that's a piece that isn't readily a part of your thinking system. You don't have that immediate support system, as many people do growing up in some way. So as far as would it be possible? Absolutely. Could I have thought of that on my own? Not necessarily.

I also have this huge sense that this is my responsibility. And at that point, the shame factor was a piece of it. I didn't want to go out and let all these other people outside of this therapy room know about these things. Now I'm certainly not ashamed of it. Now I can consider those

things. But at the time-- I think that's a marvelous suggestion, but it wasn't one that was even thought of.

SENATOR GORDON: The thought just occurred to me, we have in the past created an ombudsman for the institutionalized, elderly, and similar positions across the State to assist populations that we feel need someone advocating for them. And the thought occurs to me that there might be some opportunity. I mean, it sounds like a big government kind of solution. But it seems to me that there may be an opportunity to create this kind of expertise and make it available to people who are out there who don't know how to deal with the claims process or what the latest rules are in a particular managed care company.

MS. SPECTOR: You learn fast.

SENATOR GORDON: I'm sure.

MS. WOODS: And the other problem is, sir -- I hate to interrupt -- but you get these people on the telephone, and you try to speak to them as a normal human being. And they get so sarcastic because we don't know what they know. But sometimes they don't know themselves. So how can somebody talk to us with intelligence when they don't know the problem themselves?

SENATOR GORDON: Right.

Senator Ruiz.

SENATOR RUIZ: Thank you, Chairman.

I think that that would be a great idea for us to look into. I want to thank the three of you for sharing your personal stories with all of us today. And from just the early testimony that we're hearing, evidently

this begins to just open up the surface. We have to create a better blueprint for preventative, for treatment, and for post-therapy.

But one thing that was consistent in all of the testimony that we heard today from the three of you -- from different dynamics -- we kept hearing the word *managed care*.

And I want to say this, Chairman. While we are speaking about a specific subject matter when it comes to health insurance and managed care, managed care seems to approach every dynamic in the same way. The person on the other side seems to know what is in the best interest of the patient. Oftentimes they'll be quick to go ahead and approve surgeries as opposed to treatment or therapy and preventative efforts. And so that's probably another avenue that we should explore through this Committee, or in the midst of doing it, in the same way. It is frustrating, for certain. Particularly, I think -- at least all of you are advocates in your own rights. You have reached out, you have called, you have claims and you have pursued. We do have individuals who will get a letter, in fact, to say you are terminated, and they just take that for what it is, not even recognizing that they can make phone calls and approach it in a different way. And so I just, again, want to thank you.

And to the Chair of the Committee, managed care seems to oftentimes be at the focal point of discussions across the board when we're talking about treatment in different capacities.

And to the three individuals here, thank you, again, for just sharing your personal testimony.

SENATOR GORDON: Thank you, Senator Ruiz.

Senator Buono.

SENATOR BUONO: I too wanted to thank all of the individuals on the panel who came up to share their story. I know it couldn't have been easy.

As a number of people in the room know, I've been an advocate for mental health parity for many years. Senator Vitale and I worked very hard to get that bill out of the Health Committee on numerous occasions.

But what defines this issue for me-- What I'm hearing is disturbing. But I can't get away from the perception that what defines the issue for me is that it seems as though in the 21st century, we are still in the Dark Ages when it comes to attitudes toward mental health and substance abuse treatment. It seems as though there is still this sense of blaming the victim. And I think that disparity in treatment -- in coverage -- I think it reinforces that stigma. And you spoke of the issue of being dually diagnosed. I have family that are in mental health and psychiatric on the provider side and on the patient side, and so I know that more often than not that's what patients present with -- being dually diagnosed. And so let's hope that eventually what comes out of this Committee and other committees to come is that we eventually achieve true mental health; and included within that, substance abuse parity in New Jersey. And hopefully we'll be leading that charge.

MS. SPECTOR: Thank you.

MS. CLEMENTS: Thank you.

MS. WOODS: Thank you.

SENATOR GORDON: Thank you, Senator Buono.

I think this might be a good point to just, for the record, note that the Association of Health Plans -- the organization that represents

managed care organizations was invited and actually had intended to testify. But because of a medical emergency on the part of the witness, we were not able to hear from them today. But I would expect that they're going to submit written testimony. And as we go forward, we will certainly give them an opportunity to present their side of this story.

Thank you all very much for testifying.

At this point we will hear from Debra Wentz, who is representing the New Jersey Association of Mental Health and Addiction Agencies.

D E B R A L. W E N T Z, Ph.D.: Thank you.

Good morning, Chairman Gordon and members of the Legislative Oversight Committee.

I applaud you for calling this hearing. It's an important step toward meeting the critical need to ensure that every New Jerseyan can access behavioral health care services.

I'm Debra Wentz. I'm CEO of the New Jersey Association of Mental Health and Addiction Agencies, known as NJAMHAA. NJAMHAA is a statewide trade association representing 180 nonprofit, hospital-based and freestanding providers of mental health care and substance use treatment and services. We have 98,000 employees who serve more than 500,000 children and adults each year. Our mission is to maximize our members' ability to deliver services to the increasing number of individuals in need. Parity of insurance coverage and adequate reimbursement rates for providers are essential for achieving this mission. It's a mission that is critical for New Jerseyans to lead healthy, productive lives, as well as for the State to strengthen its bottom line.

One in five New Jersey residents has a mental health disorder. However, only 30 percent of them are able to access treatment. Many individuals with untreated mental illnesses have co-morbidities such as heart disease or diabetes, which are also commonly not treated. The lack of health care results in an average lifespan that is 25 years shorter than the general population. Meanwhile, 800,000 New Jerseyans have substance use disorders, and fewer than 7 percent are able to receive treatment. Co-occurring mental illnesses are common, and these concurrent disorders, when untreated, result in an even shorter life expectancy -- 37 years shorter than the general population.

These numbers are tragic, but they can also be reversed. Access to behavioral health care is critical to reverse this trend. A comprehensive State parity law, and adequate and realistic reimbursement rates for providers are essential to ensure this access. Equal access to treatment for mental illnesses, substance use disorders, and medical care should be viewed as a fundamental right. Anything less is discrimination.

Both the Federal and the current New Jersey State parity laws are positive starts toward ending the discrimination. In fact, in some instances, our State legislation goes further than the Federal law. However, the State law needs to do more. It must be a full, comprehensive parity bill for mental health care and addiction treatment that covers all conditions outlined in the Diagnostic and Statistic Manual of Mental Disorders and the American Society of Addiction Medicine's Patient Placement Criteria.

By passing a comprehensive parity bill, there will be true parity, not just incremental coverage defined by the plan you have or the type of coverage your employer provides. Detailed recommendations are included

in the packet and appendices that I provided you with, with my written testimony.

The current State parity law applies only to biologically based mental illnesses, which do not include eating disorders, post-traumatic stress disorder, substance use, or many emotional or behavioral disorders experienced by children and youth. These limitations lead to denial of care that could prevent crisis.

In addition to parity, an essential solution to ensure unimpeded access is to develop adequate reimbursement rates for community-based behavioral healthcare providers. They make up the safety net where uninsured and underinsured people go and are not turned away, because these nonprofit providers are driven by their mission to serve this population. This means when a commercial insurer denies visits or does not prior authorize treatment, or when individuals simply use up their allotted coverage or do not have coverage, they come to the public community behavioral healthcare system for service at the taxpayers' expense.

Services that our members provide are cost-effective and proven to enable individuals to manage and even recover from mental illnesses and addictions. The cost, as well as the value of providing these services, must be recognized. Providers must be paid adequately to deliver the quality services and treatment that will enable individuals to achieve recovery.

Usually, you get what you pay for. But in the case of providing the treatment and services for mental illnesses and substance use disorders, the return on investment is huge. And if there is not adequate investment, then the cost to taxpayers in the consequences of untreated mental illness and addictions can break the bank. In fact, a July 9th *New York Times*

Magazine article stated that the hidden costs of reduced earnings, unemployment, homelessness, and incarceration are a staggering half-a-trillion dollars annually in the U.S. Current medical necessity denials cost the State in both direct and indirect costs. When insurance companies deny services, individuals turn to public resources for treatment, shifting the cost, as you mentioned, Senator Gordon. Untreated and undertreated cases of addiction alone cost the New Jersey and public employers in our state more than \$262 million each year.

Although most of our members are designated by the IRS as charitable organizations, they are businesses and must be recognized and treated as such. There is no magic or alchemy that will enable providers to deliver higher quality services to an ever-growing number of people without the necessary level of payment. Reimbursement rates must support providers' viability as the businesses and economic engines that they are in supporting New Jersey's fiscal base.

Our members struggle to meet the exponentially increased demand for services, which resulted in part from Hurricane Sandy, other natural disasters, the economic downturn, and manmade tragedies such as the recent shooting last week in Hamilton.

Traditional Medicaid rates do not cover the cost of services and, therefore, impose a great challenge for providers and harmful limitations for individuals in need of behavioral healthcare services. For example, currently a psychiatrist is paid \$9 for a medication-monitoring session and an addictions counselor receives \$8 for one session of group therapy. These woefully low Medicaid rates -- among the lowest in the nation -- prevent providers from paying adequate salaries. As a result, they

struggle to attract and retain the workforce that is needed, and children and adults wait for weeks or even months to receive services. And while they wait, they often end up in more costly levels of care, such as emergency rooms and hospitals.

As the State plans to move to a managed-care model with an Administrative Services Organization under the Comprehensive Medicaid Waiver, it has engaged the consultant Myers & Stauffer to set rates for mental healthcare and addiction treatment services. While there will be opportunities for stakeholders to provide input, we are repeatedly reminded that there are limited dollars. Now is the time for the State and the consultants to get the facts.

Here is where the rubber hits the road for parity. As the system will face increased demand with the Medicaid expansion and introduction of the Health Insurance Marketplace starting in January 2014, New Jersey will need providers to serve the new enrollees, the traditional population, and those served by third-party payers in the commercial market, as well as those who are not accessing service. Also, the State will have other people who have been Medicaid eligible but previously did not enroll. All of these groups, the State estimates, will mean that an additional 65,000 individuals without access previously will have behavioral health issues and need treatment and services.

Rates will have to be high enough to cover the cost of care that is needed, and with all the requisite quality incorporated to obtain results. Reimbursement rates need to cover not just the clinical services, but also the cost of maintaining businesses that provide these services. In addition, the community mental healthcare and addiction treatment system has the

high cost of meeting standards for best practices and to pay for the costly infrastructure requirements imposed by State regulations on the public system. These high standards of care, to provide quality services and evidence-based care that works, are deserved by the people treated; but there is a cost, and community providers have to be paid to meet them. Again, NJAMHAA developed detailed recommendations to address these issues, which are included with my written testimony.

The bottom line is that rates have to pay for the types of services to achieve the desired rate (*sic*). When adequate rates are paid, ultimately both money and lives will be saved.

When mental illnesses and addictions are not treated, the result is worsening health conditions that require high-cost emergency and acute healthcare services, and cost shifting to government and taxpayers. Untreated disorders also increase the risk of homelessness and involvement in the child welfare and criminal justice systems, which also cost the State hundreds of millions of dollars.

Again, in the case of providing behavioral healthcare services, the return on a modest investment is huge. For example, community outpatient services cost less than \$600 annually per person, whereas it costs \$178,000 to treat one person for a year at Ancora Psychiatric Hospital. Drug Court costs approximately \$20,000 to provide six months of residential treatment, and outpatient treatment costs even less. By contrast, it costs approximately \$47,000 to incarcerate one individual for a year. Community-based services are also much more effective. For example, 30 percent of inmates who receive addictions treatment may end

up back in jail, whereas 70 percent of non-treated inmates are likely to be reincarcerated.

Unimpeded access to community-based services also yields significant cost savings for businesses. Some employers claim that it is much too expensive to offer insurance coverage at parity. But the reality is that the investment is minimal -- an average 1 percent increase to health insurance premiums. And it is negligible compared to the millions of dollars that would otherwise be spent on absenteeism, lost productivity, and workers' compensation claims.

On the commercial sector side and managed Medicaid side, many of the utilization management tools used by insurance companies delay care unless an individual and provider know how to jump through hoops with the long processes, denials, and limitations of certain insurance plans. These restrictions must be eliminated.

In addition, in the case of treatment for mental illnesses and addictions, habilitative services must be broadly defined to allow services that work to develop necessary life skills that did not exist prior to these illnesses. Children and adults with mental illnesses, addictions, and emotional and behavioral disorders deserve the same treatment as individuals with other healthcare needs. When they receive these vital services, only then is when there will be parity. Our State overall, and every resident in our state, deserve opportunities to be strong and to thrive.

Thank you for making that a reality by ensuring access to care through implementation of a comprehensive State parity law, and ensuring provision of adequate payments to behavioral healthcare providers.

Thank you.

SENATOR GORDON: Thank you, Dr. Wentz.

I have a couple of questions.

You spoke of the importance of trying to get adequate reimbursement so that there is an incentive for providers who provide the care. I've been working in this area of a while, but I have to plead ignorance. How are the rates established for Medicaid, for example? Is it something that's just done by regulation by the State agency? Are there Federal guidelines involved because it's a Federal-State partnership? Could you-- How do we go about trying to get rates up?

DR. WENTZ: Well, first of all, there are Federal guidelines that say, essentially, that the rates have to be high enough so that there is access to services. And many years ago I know that we wrote the State and asked them their process, and it was not provided. And that's been one of our major goals for many years. In fact, some Medicaid rates haven't changed since pet rocks were the latest fad and postage stamps cost \$0.08. So they definitely haven't kept up with the times.

The movement to the Administrative Services Organization, under the Comprehensive Medicaid Waiver, is providing an opportunity to -- because all of the Medicaid services -- well, with some exclusions of certain types of services, but in general -- will be moving to be managed by this entity. So that is the rate-setting process that is currently taking place. And we're very concerned because, while we're in a work group and will be meeting with them, we believe that if the rates do not reflect the true cost of providing care and the infrastructure costs so that you can run a business, when they move to this model it will end up, instead of including more people, excluding more people. And so this is the most critical point -- is

when these rates are being determined. So the State is going through this process.

But the reality is, when there are people who don't have access, that is-- You can get in touch with the regional and the Federal Medicaid office. I mean, we have a very good working relationship with our State Medicaid Director and the people there. But the rates are inadequate, and they long have been. Which is why our provider agencies have had to supplement the rates both with some of their contract dollars and doing an extensive amount of fund raising, and also other -- diversifying their business to bring in other revenues.

SENATOR GORDON: So, from what you're saying, this is a critical time now as these ASOs are being established.

DR. WENTZ: It is.

SENATOR GORDON: What kind of leverage does the State Legislature have in that process? I mean, how can we as the State move those rates up?

DR. WENTZ: Well, certainly you could make it known to the Administration and the Department of your concern, and ask to be invited to the table as part of the stakeholder group. I mean, it is an administrative regulatory process. But I don't know if you -- a simple request might be honored or if it would take legislation in order to ask for oversight. But I think I would begin by asking that there is a representative -- whether it's staff or a legislator -- who could be part of the process and apprised of it as it's happening, and not after the fact when it's too late.

SENATOR GORDON: Another question: One of the roles of this Committee is to provide oversight over the operations of the Executive

Branch. I think we call that *checks and balances*. Are there things that DOBI or other State agencies should be doing to do a better job of enforcement or monitoring of what's going on in the mental healthcare marketplace?

DR. WENTZ: This is also, again, a critical time. While the -- to its merit, the State Medicaid division has defined an alternative benefits package for the expansion -- Medicaid expansion population, which will be used by those in the healthcare marketplace. And not to get you lost in the technicalities, but mental health and addictions has to be one of the essential benefits. And we've met with the Department of Banking and Insurance for the last two years, telling them that the commercial network's restrictive, narrow definition of *medical necessity* -- and even their definition of the Federal parity -- which these small business plans do have in their contract-- It's like having blinders on in terms of treating our population. In particular-- And that's why I mentioned habilitative services in my testimony. Rehabilitative services -- think of like when you get a hip operation or something -- you used to be able to walk, and you go to regain your ability to walk. Habilitative services is for people who have serious mental illness and addictions to develop skills that -- because of their illness people may have never had skills of daily living, how to take a bus to get to your appointment, how to cook a meal, how to go to school to learn something, to learn a trade.

So we did speak, and they were open to it. But the State has lost-- I guess a lot of people have-- And they're very overextended. So the State internal workgroup that was supposed to meet prior to my coming back to the table with representatives of my membership to discuss with-- Actually, it was Neil Sullivan and Ellen DeRosa from the Department of

Banking and Insurance who were open to seeing how they might need to modify the definitions of *habilitative services* and *parity* so that it really would meet the needs of the treatment population. So we're waiting for the State to finish its part. But we will be reaching back out. But that's an area, too. I believe now is the time because in -- they're redoing the State's contracts for the health maintenance organizations. And those contracts will define the scope of service, and how it's defined is how the companies deliver it. It's a contractual arrangement.

And building on what Mary Ditri said -- and I have to applaud it -- we've also been working with the health maintenance organizations that are currently contracted with the State for three years. And I think that that collaboration is essential in terms of getting to know each other and what the provider treatment is. There were company members who had the impression, for example, that somebody who had a serious and chronic mental illness was going to -- much like in a commercial plan -- take their insurance card, flip it over, and call the vendor for behavioral health services. When someone doesn't even have the insight into the illness, in many cases, or they're not well enough or don't have the functionality at the time to do it, or they don't believe they're sick because they're psychotic, that's just not going to happen. So having that collaboration so they understand the population is important. But this is a huge undertaking. It is complex, as Dr. Miller said.

SENATOR GORDON: No doubt.

Senator Ruiz, any questions? (no response)

Dr. Wentz, thank you very much.

DR. WENTZ: Thank you.

SENATOR GORDON: We're going to bring up another panel.

In the interest of time, I would ask everyone who has yet to testify that rather than reading extensive testimony, if you could, summarize it or speak extemporaneously in making your points. I think that way we'll move more efficiently today.

At this point I'd like to call up Nancy Walsh, Debbie DiColo, Jodi Bouer, and Lee Geiger-Miller. Again, these are all individuals who interacted with the system.

Thank you all. Please proceed.

J O D I F. B O U E R, ESQ.: I hope you don't mind if I go first.

My name is Jodi Bouer.

Thank you for the hearing.

I'm an attorney in the state whose practice focuses on representing people who have mental health issues and forcing insurance carriers to pay claims that they don't want to pay.

I'm here today to read some testimony into the record of a provider who couldn't make it. But because I'm an attorney and am familiar with ERISA, if the Senator wants his question answered about ERISA, I would be glad to answer that now or at the end of the testimony.

SENATOR GORDON: Okay. Why don't you address this ERISA issue, because I'm trying to understand if we, in fact, have as much leverage as we really need to improve the system if the Federal government is precluding us from action in a whole part of the insurance sector.

MS. BOUER: Sure. Medical necessity guidelines, authorization guidelines, claims processing guidelines are all internal guidelines by insurance companies. There is nothing in ERISA that bars the

State from enacting statutes and implementing regulations that stop the shenanigans that we've heard here today and that I see in my office on a daily basis -- absolutely nothing. So it behooves the State to start to regulate this activity and stop insurance carriers from doing this horrible activity to folks. I think the ombudsman idea is a great idea, frankly.

SENATOR GORDON: Thank you. That's very helpful.

MS. BOUER: The person I'm here to testify for is Bobbie Gallagher. Bobbie Gallagher is a behavior therapist who works with children on the autism spectrum. She also has a child on the autism spectrum. And she worked as a clinician for a TPA and left the employment of that TPA because of the unethical practices that the TPA was asking her to do in her practice. She needed the insurance, but she valued her ethics more than the insurance. So here is her testimony.

She says, "I know that insurance companies and third-party administrators will tell you that the complaints of the consumers are isolated and not the norm. In addition, they will explain that they have policies and procedures in place to prevent such events from happening. But I speak to this area from two place: First, as a third-party administrator clinician who left my employment because of unethical practices; and second, as a mom and as a provider who has worked for Magellan under single-case agreements."

She kind of describes a couple of practices. "You would think this was inadvertent and nonintentional on the part of the insurance companies. Think again. As a TPA, many cases were transferred to us mid-authorization." She was internal in the insurance companies. "Internal meetings would be held on how to decrease therapy hours prior to

discussing the case with the provider. Scripts were used, provided to the clinicians -- the TPA clinicians -- that they could use to convince the provider to decrease the recommended authorized hours, or to make it more difficult for the provider to get an authorization or get the same level of care that they were initially requesting and that was recommended by the patient's physician.

“Single-case agreements with out-of-network providers were not permitted to families, who were forced to change from providers that they had become successful and comfortable with to new providers, causing delays in services and regression. Only those families who were familiar with their rights or who would push the insurance carrier or the TPA into providing information to allow them to elevate services would be given that information.

“Preferences were given to large provider companies, especially those that joined task forces. And smaller companies were not given the training they needed to submit treatment plans, enter billing information, etc., which would cause great delay in the payment of their claims and cause these smaller companies to avoid treating patients.

“There was no standard treatment plan or checklist that could be used for providers, and therefore the authorizations or requests for information varied depending on the case manager who was managing the claims. Case managers would make requests for additional information from providers intentionally, instead of asking for all the missing information at one time, in order to delay the authorization and save time.”
I see that all the time in my practice.

“The TPA would inform the TPA paid staff clinicians if a provider -- if a case was a capitated case or a fee-for-service case, and suggested the clinician audit the case more carefully and decrease hours if it was capitated. The reason is, a capitated case agreement with an insurance company has the TPA -- the capitated accounts pay large amounts for the TPA to manage their cases. All the services provided to the member are paid for and deducted from that account. Any money that is left over at the end of the year is profit. So it’s intentional.”

SENATOR GORDON: Profit to the TPA.

MS. BOUER: The profit is to the TPA.

As a provider -- because she’s on both sides now -- as a provider, she has encountered numerous delays from insurance companies. Often her clients were told they owed deductibles close to the amount charged, and she was not paid once the deductible -- even if it didn’t happen -- once a deductible was made. Once it was understood the deductible was not needed because there was a single-case agreement and it was considered in-network -- and that could take 30 days to clear up -- it would take another 30 days for her to get her payment. The process was repetitive each month. And as a small agency, she was having a very hard time staying in existence because of the constant delays. And I can tell you as a lawyer that I’ve gotten numerous calls from providers saying, “We can’t keep up with the low reimbursements and the delays in reimbursements.” And certainly the delays in reimbursements can be addressed by the Legislature here. In fact, there are regulations on the issue.

She’s asking the Committee to look at the families who are presenting their issues to you, not as the minority of those receiving

services, but as the norm. Many families just give up attempts to try to get coverage. Because of repetitive denials, appeals, claims authorization issues, other families will endure what happens, and it adds on to the anxiety and stress of their life.

I handle mental health appeals all the time for my clients for residential treatment. And over, and over, and over again I see kids -- mostly kids who are in desperate need. And their families go deep, deep into debt because they have to pay for residential treatment for a kid who has severe mental health issues because the insurance carrier has determined that there is no medical necessity. In one case, there was a child whose family came in. He was sleeping, on home visits, with a knife under his bed because he thought somebody was going to come and get him. And when he went back to the facility, he couldn't leave his mother's car because he was afraid of leaving the car. And yet the insurance carrier, despite that information, was denying the residential treatment that this child had. The father had to go back to work in his 70s to pay for the treatment while we were appealing. The family has since divorced. It has absolutely destroyed this family. And over, and over, and over again I get calls from this family because every time this child is transferred from one facility to the next, they go through the same problems. The carrier does not want to pay.

I don't know if you have any questions, but I'd love to answer them.

SENATOR GORDON: Ms. Bouer, that was very helpful. It seems that what is of critical importance is the definition of *medical necessity*. That could be a real point of leverage to have a positive impact; and it's something that I think we could do, from what you're saying.

MS. BOUER: Absolutely. The problem is that the insurance carriers are disregarding the recommendations of the mental health providers of families in order to save money based on a criteria that is very subjective. And it's very problematic because these families cannot fight the insurance companies at the same time they're trying to deal with their children's or their family member's mental health issues. We can't leave it to the insurance carriers that are driven by profits. You have to leave it to the providers.

SENATOR GORDON: Thank you for your testimony.

Let's turn to Ms. Walsh, Ms. DiColo, and Ms. Miller.

Again, if you could summarize your comments -- as opposed to reading a statement -- just to make your main points, we'd appreciate it.

NANCY WALSH: My name is Nancy Walsh, and I'm here to be an advocate for my son.

In December of 2006, my son was 18 at the time, attending Rowan University. Just before final exams he was assaulted -- rather, attacked -- by a group that came in -- a gang that came in from outside of the school. We were told by police it was some kind of initiation for a gang.

While his physical injuries amounted to no more than bruises and a concussion, he suffered a full mental breakdown two weeks later that his doctors directly attributed to post-traumatic stress syndrome due to the result of the assault. He spent two weeks in a mental ward in an area hospital and was diagnosed with a not otherwise specified psychosis and paranoia. He was put on heavy medication and then released back into the world. His life that he knew was changed forever by this horrific event. He

no longer was able to hold down a job or return to college. And he was even shunned by all his long-time friends for his bizarre behavior.

Early on he was receiving outpatient therapy sessions that did not seem to help him. We soon began to realize he needed intense treatment in a hospital or mental health facility. When we tried to get him that kind of intensive help he desperately needed, we quickly discovered we were stuck in a horrible catch-22. Unless he was a drug addict, an alcoholic, or a harm to himself or to us, he was not able to be covered under managed care for the long-term residential treatment he needed. On more than one occasion we were told by various facilities that we contacted and the therapist he was seeing that we should lie about his situation and tell them that he was either a drug addict or an alcoholic to get him the concentrated help that he so desperately needed at that time -- such as Princeton House or Carrier Clinic.

In the spring of 2012, my son was acting strangely after being pulled over by a police officer on a traffic stop. He was taken to the police station and jailed. He then began hitting his head against a wall. My son was transported to a hospital in Red Bank by the police. So now he was deemed a danger to himself, which was a silver lining in this situation. He was involuntarily committed to Carrier Clinic. And finally, over the following month, he received the kind of intensive care he needed all along.

Although my son will probably never be the same, I am happy to say he has progressed to the point that he now holds down two part-time jobs and attends Brookdale Community College, where he's gotten some good grades -- Bs.

I feel very strongly that if he had received the help that he needed many years ago that Carrier did for him, he would not have lost the six years of his life. I urge all managed care to look at this absurd policy and treat people with mental illness as soon as possible so that they may resume productive lives. I would also like to say that it would save people such as my son and their families great heartache and despair.

SENATOR GORDON: Thank you very much.

Either Ms. DiColo or Ms. Miller.

LEE GEIGER - MILLER: Hi. My name is Lee Geiger-Miller, and I'd like to compare and contrast my journey through life-threatening diseases in both the medical and mental health capacities with my insurance.

I'm a retired educator and was Vice President of my local chapter of NJEA. Unfortunately, I am in a unique position. In February of 2005, I dealt with a sudden, life-threatening medical crisis concerning my husband. So began our journey through medical health care with an emergency room care team. My husband had Leukemia -- he had AML Leukemia. What happened was, I was consumed by shock, fear, and ignorance. And what emerged for me was a plan to become my husband's advocate.

Guidelines emerged in my brain to assess and find the best quality care for my husband. I'm going to use these criteria to compare my son's experience later on. Criteria one: quality and availability of services in network -- excellent. My husband went from a local emergency room in the local hospital within 24 hours to Jefferson, which is a hospital in Philadelphia that specializes in the type of Leukemia he had.

The timely manner of providing services: Upon his first evaluation, he ended up in Philadelphia within 30 hours. He was moved because of the seriousness of his condition.

The ability of care providers to communicate and coordinate services: criteria three. We were kept in the communication loop. At no time was there any denial of services or evaluation of services provided by a third party just reading his file. The professionals we encountered were willing and able to share and verify information, and describe treatment options for us. Michael opted for a clinical trial and was moved to the Jefferson bone marrow unit.

Criteria four: the dignity and humaneness exhibited. One of my major fears was that the providers would forget that this was an individual with a serious illness and not a statistic or just a guinea pig. My husband's condition deteriorated unexpectedly, and I made the decision to take him off of life support. We were treated with amazing compassion and kindness during this terrible time. Michael died on March 6. He was ill for approximately two weeks. It was an incredibly painful time, but I truly felt my husband was offered the highest quality of care. It just went terribly wrong.

In terms of behavioral health: My son James suffers from the disease of addiction. Before I continue, it's important to note that my son agreed that sharing components of the appeal documentation -- which is in the packet we assembled -- was essential in telling his story; our frustration and anger at how individuals dealing with addiction are treated and is detrimental to the struggle for them to move to active recovery.

I became aware of my son's addiction in late March and early April of 2011. I was not aware of the extent of James' problem until later. My son-- I contacted my primary care physician. He recommended Dr. Shore, a psychiatrist and addiction specialist. He was out of network. I played my managed healthcare game and learned how to get the documentation and get him some of the services he needed.

I attended some of the therapy sessions and my son did also. From the period of April 11 to May 27, 2011, my son repeatedly relapsed. Dr. Shore was unwilling to continue treating James unless he went to rehab. Dr. Shore recommended three rehabs, one of which was an in-network provider. The in-network provider Marworth repeatedly would not return our calls. This is an important fact when I discuss quality and availability of services.

I decided on the Cumberland Heights facility. It was imperative that any program he went to needed to offer grief counseling, as my son had serious issues related to his father's sudden death. I also felt James was depressed, and he indicated that life was not worth living. It was also reiterated to me to expect my insurance to deny services and that I would incur additional, out-of-pocket expenses. Addiction is an expensive disease.

I still believed that health care and behavioral health would be of equal quality. What continually motivated me was the fact that my son had a potentially fatal illness and needed treatment immediately. The denial of services began, and I immediately tried to begin the appeal process. It was difficult to even begin this process as my managed care failed to return calls. I documented my calls when I realized it was going to

be a challenge. I have a copy of many calls to Magellan if you would like to see my logs.

My managed care did the expedited Level 1 and Level 2 provider appeal review, and James was deemed to meet the criteria for intensive outpatient services -- this is an important component of our story -- but not residential rehab. We proceeded to the final appeal level which consisted of written documentation and a three-way phone conference on 9/28/2011 with Magellan representatives; treating physician at Cumberland Heights, Dr. Sledge; Dale Kirkham, a Cumberland Heights Care Management Team member; and myself acting as James' healthcare representative.

In our paper documentation, I addressed the ASAM patient placement criteria for the treatment of substance-related disorders. I'm not going to read that all to you, but in your packet you will find the supporting evidence we found that hit every one of these dimensions. This appeal was also denied, but I will address my concerns when I address my criteria.

I do want you to know that James, in the height of his addiction, was an intravenous heroin addict. He was using \$200 a day of heroin. He was in eminent danger of overdose, criminal involvement, and/or some of his little drug dealers he owed money to -- we were in danger of them coming to our home. So at your leisure, please look over my dimensions. My whole point of including the ASAM dimensions is the clearly subjective nature of interpretation of these guidelines.

We lost the final appeal. And I had submitted information for an appeal at the State Health Benefits Commission. I was an angry woman. Interestingly, on 12/20/11, my managed care provider reviewed their

records and decided to authorize the residential substance abuse treatment because of an error in wording on a letter dated 8/16/11. I will be pointing out more about inaccuracies in communication when I discuss my evaluation criteria. My managed care considered the appeal closed. Please refer to document 5. I would be willing to share the appeals if anyone would like to see them.

Behavioral health, criteria one: quality and availability of services in network. This has been a very real problem with my managed care. One of the rehabs recommended by my son's treating psychiatrist was in network, but they wouldn't return calls. I was given a list of psychologists and psychiatrists that were in network. Several did not return calls, and many did not handle addiction cases. My son ended up seeing a counselor through Danellie Counseling Center, an in-network provider, but the counselor did not have a background in addiction. When my son was in Cumberland Heights, I spoke with a managed care management representative, and we reviewed IOP programs in network for when he was going to transition back to New Jersey. We decided that as part of his continuing care program, we would use Princeton House because it offered family and grief counseling. When we finally did do the evaluation at Princeton House, we were told that they did not, at that time, offer grief counseling.

Criteria two: the timely manner of providing services. There was a serious problem when James was preparing to return home from Cumberland Heights. I went for the family counseling program at Cumberland Heights a week prior to my son's release with the information discussed with the managed care management representative. I had

obtained preauthorization for the intensive outpatient program at Princeton House. Cumberland Heights repeatedly tried to contact Princeton House to set up an evaluation as soon as James returned home. I was going to touch that plane down and head to Princeton House. They were unsuccessful. Cumberland Heights did fax over records. My son called 6/30/11, and he was told he would receive a call back by Friday, 7/01/11 before 6:00 p.m. We called at Friday at 3:00 p.m. and talked to an answering machine. We called 7/5/11 and asked for assistance and was then directed to a voicemail. We were then told they were waiting for the toxicology reports from Cumberland Heights. We called Cumberland Heights and got another set sent. We called 7/7/11 and again on 7/8, and were told we would get a call back. There was no call. Finally, James was given an appointment on 7/9/11 at 11:30. At this point we were given general information paperwork which could have been faxed or mailed in. That was it. And we were told that they would get back to us. We got a call on 7/14/11 and were scheduled for an appointment on 7/20/11. Remember, this is three weeks back in the community with no services. The meeting was a full intake, and we were told he was eligible and James could begin that evening. At 5:00 p.m. I received a call from his counselor at Princeton telling me to tell my son to go home, as Magellan concluded he didn't meet the criteria for an intensive outpatient program.

Now remember, we went through a lengthy appeals process and were told repeatedly that he clearly qualified for IOP. I called again the next day for clarification, and I was told James was rejected for the program because of the three-week lapse between his return and his full evaluation on the 20th. I pointed out that it was due to Princeton House that he was

not seen immediately upon his return to New Jersey. I was told that I needed to be calmer about the whole thing. I was insulted.

My son relapsed soon after and went back to rehab. I began a complaint process, and enclosed is their response, Document 6. They completely failed to acknowledge any of the earlier calls. I felt this whole situation was unacceptable.

Criteria three: the ability of care providers to communicate and coordinate services. The events listed above clearly indicate a failure to coordinate anything. My son's life was in danger. I was repeatedly given care options that were inappropriate to my son's needs.

Criteria four -- and this, I think, speaks to every person who has dealt with addiction in this room or dealt with the mental health system in this room -- the dignity and humaneness exhibited. I felt my son's treatment through Magellan was unacceptable and demeaning. The letter we received stating that the final appeal had not gone in our favor had several particularly upsetting points. Please refer to Document 7. It notes a Donna Fisher was a part of the phone conference. She was not. Dale Kirkham was the Cumberland Heights representative. On Page 1 the letter referenced the treatment facility at Cumberland Heights, which was where my son was. On Page 2, the document refers to James' stay at the Betty Ford Clinic. James has never been, in any way, affiliated with the Betty Ford Clinic. This led me to believe that my son's file was either mixed with another person's appeal or that we received a form letter that was sent to all who made it to that level of appeal. This was demoralizing to both my son and myself. This letter is dated 10/5/11. And on Page 3 it states, "Clearly fits the criteria for IOP," which he was denied on 7/20/11.

Document 5: the letter of 8/16/11. Again it states, on Page 2, that James fits the criteria for IOP, which he was denied on 7/20/11. Also, this letter states -- this one really kills me -- "It cannot supersede the professional judgement of the treating provider." I felt Magellan never listened to the psychiatrist who was treating my son. The whole behavioral health system that we utilized can only be described as a dangerous contradiction.

In conclusion, Magellan's treatment of my son was completely demoralizing and a deterrent in his pursuit of active recovery. In spite of all this, and after a gut-wrenching, harrowing two years, James will be celebrating, on August 4 of this year, a year of active recovery. I am grateful that my son had the courage to pursue sobriety. Both my son and I realize that addiction is something that he will need to be vigilant about for the rest of his life.

I am actively involved in NAR-ANON, and I work quite a bit with family members who are new to the family disease of addiction. One of my main points to loved ones of addicts is to not accept no for an answer in terms of treatment and to keep extensive and accurate records.

Thank you for listening to our story.

SENATOR GORDON: Thank you very much.

Ms. DiColo -- and, again, if you could summarize, we still have a number of people we want to hear from today.

D E B O R A H A. D I C O L O: Thank you for giving me the opportunity to speak today.

My name is Debbie DiColo. I am here on behalf of my sister and brother-in-law, and I'm here to tell you the story of my nephew.

My nephew was 16 or 17 -- to tell you the truth, it's a blur -- and I got a call when I was at work that my sister was in the emergency room at Helene Fuld. What happened was, she had gone to wake him up, and she couldn't get him awake. So she called the squad and they came and got him. I met her and my brother-in-law at Helene Fuld. He was in complete system failure. He was in cardiac arrest. He was bagged; his lung was punctured. To make a long story short, they Medevaced him to Children's Hospital in Philadelphia, and they saved his life.

This was my-- I lived the *Reader's Digest* story that I would read about with overdoses, where the parent goes up to wake their child up for school and cannot rouse him. And we experienced that.

It's one of those things that-- A prior speaker said this problem is complex. It's complex until it gets personal. And this issue is personal to me. My nephew spent 23 days in CHOP in intensive care. He was hooked up to every machine imaginable. When I saw him at Helene Fuld before they Medevaced him, his ears were gray, his toes were gray, his fingertips were gray. In essence, he pretty much was dead. And we just did what we always did in my family, and we just started to pray. And we called everybody we knew and asked them to pray.

So Children's Hospital was able to bring him -- and keep him alive and bring him to where he is now -- a person who has gone through the journey that has been explained by other people. And it was a horrible journey because of his age. Because nobody knows how to treat them. And so when he was in Children's Hospital, he was there a week, and my sister got a letter from the insurance company saying they denied services -- one week. And he was hooked up to every machine I could ever have seen. He

was-- The 9-1-1 ambulance was originally considered out-of-network, and partial payment was demanded. The Medevac helicopter was considered not covered and after six months of fighting, it was then deemed to be considered out-of-network, and after many calls and two months later, it was finally completely covered. I guess they thought we had a helicopter in the backyard, because there was no way we knew whether a helicopter was in-network or out-of-network.

Later in the stay at CHOP, the primary physician told my sister and brother-in-law that he would be moved from intensive care to a regular floor because the insurance company was no longer going to pay for the intensive care -- not that he didn't need it; they weren't going to pay anymore. The floor wasn't equipped with the machines that he needed. My brother-in-law and sister were actually helping the nurses figure out how to work them.

The medical coverage allowed 30-day in-patient stays. I'm trying to skip around, so I'm probably losing something. He was eventually transitioned out of CHOP to an in-patient drug treatment center, and they wouldn't let him stay for 30 days, even though that's what our insurance said he could have. That was the minimum. And that was because of Magellan. It's plain and simple. Magellan said no. Who is Magellan? I mean, we got a real education. It's not a person. But somebody is making decisions that could have killed my nephew.

After he got out of that drug treatment center that he wasn't allowed to stay for the duration he needed, it began the cycle of short stays in in-patient facilities. Then he had to come out and go to outpatient facilities. They sent him to White Deer Run. He wasn't allowed to stay

there the whole time. And he went to outpatient again. Then he had to go to Livengrin Rehab, and another in-patient stay -- short, not the full time again. Then he had to transition to the out-of-state Recovery Institute of Florida. That was when we finally got a shot at him surviving.

My nephew, my sister, and I, and our family -- we're middle-class America. He's a suburban kid. My sister -- at the age of 17 or 16 -- had to send her son away for him to get treatment and give him up to strangers for help, because that was the only way he was going to survive.

When he got down to Florida, the same cycle continued. He was transitioned to outpatient. He would relapse and go to the Recovery Institute. He would go to a different town and relapse. He got into an in-patient at Palm Partners. It was another short stay, another transition to outpatient. It sounds like years, doesn't it? It sounds like years. My nephew is now 22 years old, and he's alive. He is in recovery, and every day is a gift. He has taught me what hope is. I always knew that -- faith, hope, and charity -- I always knew what faith was, I always knew what charity was, but I learned what hope was. And that is what he has taught me. Because without it, he wouldn't be where he is today. He is a survivor of a system.

We had insurance. We had the State Health Benefits Plan. We were in the traditional plan and then in the PPO plan. We had the best health plan. Everybody knows we do. That's why everybody hates people who teach in public schools -- because we have great health insurance. Well, guess what? Nobody told them about Magellan. Because Magellan is taking our money and putting our children and our family members at risk. And we have nowhere to go to stop them.

I happened to be the local president at the time. And my sister taught in my district, and was a colleague as well as my sister. So I knew what my health plan was. I had a personal relationship with the representative from Horizon Blue Cross Blue Shield. And when I called him for help, he didn't know me anymore. I called everybody and anybody I knew -- how to help me through this. Because I'm the big sister. I called an old friend who was in family counseling down the Shore who dealt with addiction. And, you know, my nephew was typical of what you're reading about in the papers now. It was all prescription drugs. It was OxyContin. But we all know it's not just one drug. We were lucky my nephew was never arrested; we were lucky my sister never had to throw him out into the street and let him live on the street; we were lucky that he finally got it, because my brother is a captain in a police department. And my sister told him, in no uncertain terms finally, "Either you go to the rehab or you're going to jail." And that's what saved his life. That's what saved him.

And we had insurance. And because we-- My sister was a health educator, I'm a health educator, my brother-in-law is a health educator. We know all about drug addiction -- not when it happens to you -- and somebody gives you a phone book and says, "Find a rehab for your kid because we don't know how to deal with teenagers in the State of New Jersey. Oh, and by the way, your insurance says 45 days, but you're not getting that because Magellan won't let you have it." And that's the saddest part about it. We are in an epidemic, but the people who are responsible for caring for these people who are involved in the epidemic haven't gotten one less cent in profit over the time that my nephew has

endured this. And he will endure it, I know, for the rest of his life. I know he will.

But my sister wrote this -- and I know you didn't want me to read it -- so please take the time to read it or she will be very angry with me.
(laughter)

SENATOR GORDON: We certainly will.

MS. DiCOLO: The one part that she wanted me to make sure that I said was that this is a simplified version of five years. There were numerous medical claims to fight, daily phone calls to make, contacts to secure, paperwork to complete. Not only were we, as a family, battling a severe addiction problem, but also a powerful health insurance company and their behavioral management subcontractor. It is our hope to have the present system of micromanaging changed so other families will not have to experience the frustration that we did.

The one concern that I have is that we're now under the auspices of Magellan. And I'm sure that name is going to change, and they're going to call it another name. But they're going to do the same thing. And then when you get tired of them, they'll call it another name, and they'll do the same thing. But meanwhile, everybody is paying plenty of money for health insurance, and we're being denied the care that we've already paid for. And the people who are making those decisions are not even medical doctors, they're Ph.D.s. They're not medical doctors. And the medical doctors are saying, "This is what the patient needs," and somebody who is making a profit on them is saying, "No, I don't think so. You can give them five days, you can do seven days."

And that's our story. If you have any questions, I'd be happy to answer them.

SENATOR GORDON: Thank you very much, Ms. DiColo -- actually to all of you for very eloquent presentations that show us what's going on in the real world. I will commit to you that we're going to try to find a way of dealing with many of the problems that you've highlighted.

Senator Ruiz, any questions? (no response)

Thank you all very much.

In the interest of time, I'm going to call up a panel of three. I'd like Debra Koss, New Jersey Psychiatric Association; Jeffrey Axelbank -- Dr. Axelbank, New Jersey Psychological Association; and Luba Shagawat, Clinical Social Work Guild 49. If the three of you could, come to the table.

Dr. Koss, would you like to start?

D E B R A E. K O S S, M.D.: Mr. Chairman, members of the Committee, thank you for this opportunity to participate in this important discussion on mental health parity.

My name is Dr. Debra Koss. I'm a child and adolescent psychiatrist with 20 years of clinical experience. I maintain a private practice in Sussex County. I'm the immediate past president of the New Jersey Council of Child and Adolescent Psychiatry and current Chair of the Council on Advocacy for the New Jersey Psychiatric Association.

I am pleased to offer testimony on behalf of both of these professional organizations. And in this capacity, I represent over 200 child and adolescent psychiatrists, and over 800 adult psychiatrists practicing in the State of New Jersey.

We've already heard many of the important statistics regarding the prevalence of mental health in the nation and in the state. I won't repeat those here. But I would like to call attention to a statistic that recognizes the onset of symptoms, as it relates to the importance of recognizing symptoms in children.

Over half of all lifetime cases of mental illness begin before the age of 15, and over three-quarters of the cases begin prior to the age of 24. Mental illness is like any other disease in that the earlier it's recognized and treated, the better the outcomes. The advances that we've achieved in scientific research provided us with effective, evidence-based treatment, and yet families experience all types of barriers to care, as we've heard here today -- lack of knowledge, stigma, access to care issues, and of course mental health parity concerns as well.

As a result of these obstacles, we know that untreated mental illness results in serious consequences -- everything from school dropout, academic failure, unstable employment opportunities, coexisting substance use issues, higher risk of medical issues, involvement with juvenile detention and law enforcement, and of course, tragically, suicide. Here in New Jersey, suicide is the third leading cause of death in our youth age 15 to 24. The number of children and youth who die by suicide is higher than all natural causes combined.

The Mental Health Parity and Addiction Act had promised to put an end to the discriminatory policies that insurance companies use. Unfortunately, the promise has yet to be fulfilled. Examples of discrimination include the contractual limitations we've heard about regarding outpatient services, the number of in-patient days allowed, higher

copayments and deductibles, caps on annual and lifetime benefits, and restrictions on the use of psychopharmacologic treatments.

Testimony provided today has provided compelling examples that must move all of us forward to remain steadfast in our advocacy efforts to speak on behalf of all individuals with mental health issues. I've shared a number of examples in my written testimony, and I will highlight one example for you here today that, again, calls attention to the importance of early intervention and prevention.

I have a child in my practice with autism and attention deficit hyperactivity disorder. The parent of this child also has mental illness. The child's symptoms are severe enough to require specialized school placement, intensive behavioral interventions, and the use of medications to treat aggression and symptoms of impulsivity.

Despite the recommendations of every member of the treatment team, the insurance company has restricted the types of treatments that have been recommended, including denying any services for family therapy that would provide the parent with the necessary instruction and guidance to implement behavior modification at home; and putting a limit on the number of individual therapy sessions that the mother is able to attain for herself -- suggesting, in contrast to what the treatment team has recommended, that brief, solution-focused psychotherapy should suffice in this particular case.

Each time the insurance company has put forth one of these denials, the parent has had to discontinue treatment. And what has resulted is an exacerbation of symptoms for the child, as well as the mother.

Within this context, the parent has then had to access emergency psychiatric services.

With a condition such as autism, where we know the importance and relevance of early intervention in terms of impacting the long-term outcome for children, it is particularly devastating to hear about these kinds of restrictions and interruptions in treatment, and the unnecessary cost for emergency psychiatric care in contrast to outpatient services is senseless.

There are other examples that are included in my testimony. I'll only briefly mention the categories for you here at this time. There are other populations at risk as well. Individuals with Medicare HMO more recently have been encouraged to opt for what has been allegedly described as more cost-effective treatment plans, only to find out that under the managed HMO plan -- that they have restrictions for their mental health benefits and have to discontinue treatment. Individuals who participate in the annual renewal for their managed private insurance discover that, once the renewal process is completed, their mental health benefits are excluded because of a preexisting condition. And patients within the State system of care with Medicaid tell and share compelling stories, as well, regarding their inability to fill their prescriptions at the pharmacy because of restrictions on their plans, as well as extraordinarily long wait lists to access care or mental health providers.

Addressing mental health is a necessary component to overall medical health. It must begin with an accurate medical diagnosis, as well as treatment for evidence-based practices. Early intervention and prevention programs are a necessary component of this treatment, and integration of

community-based services is important in order to ensure that we have continuity of treatment across the lifespan; as well as communication and coordination of care between service providers, including mental health providers and primary care providers as well.

The good news here today is that New Jersey is already experiencing some of the changes. The New Jersey Council of Child and Adolescent Psychiatry, as well as the New Jersey Psychiatric Association support implementation of the principles of parity that will guarantee families and patients the full range of mental health treatment and services without the financial hardships, the stigma, and the discrimination that we've heard about here today. The specific strategies are outlined in my written testimony. I encourage you to take a look at those.

As I mentioned, the good news is that we've already begun to initiate some of these changes in New Jersey. The first way in which we've done that is through the New Jersey Primary Care Child Psychiatry Collaborative Program. This is a collaborative model which exists nationwide in now over 20 states in our country, and is based on the knowledge that more than 75 percent of children and adolescents with mental illness present first to their primary care providers. I've provided for you a summary of the best principles for integration of care. And this has served as the model for what we initiated here in New Jersey in 2012. With private funding we were able to put in place a small pilot program in Essex County. And the core component of this program was to provide psychiatric consultation for pediatricians, assisting them in the assessment of children with emotional and behavioral issues; helping to create linkages with mental health services; and, when necessary, providing consultations

so that they could initiate treatment. The program was well-received by the pediatricians and the families who participated in the program. And as you know, we are now exploring other opportunities to expand this model across the state.

Again, I thank you for this opportunity to provide testimony, and I thank you for your commitment to ensuring access to mental health services for all New Jersey residents with mental illness.

SENATOR GORDON: Thank you very much, doctor. And as you may know, I'm sponsoring legislation that would extend the collaboration to Bergen County.

Interestingly, when it was heard -- the proposal was heard at the Health Committee, many of my colleagues asked, "Why aren't we doing this statewide?" So I'm hoping that we may be able to amend the bill to make this a statewide program. But, of course, the State and the Governor would need to commit the resources to do that. But I thank you for the groundbreaking work you're doing in Essex County.

DR. KOSS: Thank you for your support. Our professional organizations are here to work with you in the implementation.

SENATOR GORDON: Thank you very much.

Ms. Shagawat, would you like to present next?

LUBA SHAGAWAT: Yes. Good morning -- if it's still morning.

My name is Luba Shagawat, and I'm here to represent the New Jersey Society for Clinical Social Workers, as well as the Clinical Social Work Guild that is affiliated with the Office of Professional Employees International Union.

I have testimony that I have written, that I've submitted, that I'm not going to read now. But suffice to say -- one sentence, as far as my testimony goes, it seems to me that the fox is in the hen house. The group that is paying for care is also the group that is deciding whether the care is necessary. And I see that as a conflict in and of itself.

The reason I'm not submitting my own testimony is because one of our members from the organization has written testimony, and she is out of the state right now so she can't be here to present it. And she asked me to read it for her. It's not long.

Her name is Stephanie Samuels, and she is the Director of the Counseling and Critical Incident Debriefing Center. Her specialty is post-traumatic stress disorder. I'm going to skip the first section, but she's considered to be an expert in both the courts as well as nationally. This is her specialty, and she is legitimate in that regard.

The State Health Benefits Plan used to have the traditional policy as well as New Jersey Plus. She says, "Neither of these policies had gatekeepers, at the time that is currently known as managed care. This permitted law enforcement officers to get the treatment they needed." Her specialty is with law enforcement. She is the person who started the Cop 2 Cop program. And it took 10 years in the making. And she is now wanting me to read this on her behalf.

"It was during the time that I began to see Patient X. There were many stressors that brought him into treatment. But in April of 2008, when the State Health Benefits Plan changed to managed care, it now required that all sessions be authorized. At first it was just really a matter of formality. It was a simple matter where you would just simply fill out a

form.” And she was flagged early on for coding 90808. What that means is that she was seeing her patients for an hour and 15 minutes instead of the usual 45 to 55 minutes. Then when the treatment began, she had to speak to a case manager after they flagged her for these codes. She had to speak with a case manager every time she sent in a request. She was speaking to someone who knew little to nothing about the population, and the police officer’s typical reluctance to seek treatment in the first place.

She began getting refusals for this code and started noticing that her patients -- most of which were police officers -- were declined. One patient was hospitalized. “I did everything to get him either 90808, which was the 75 minutes, or at least two sessions of 45 to 55 minutes. This wouldn’t be done. When I became agitated and demanded a copy of the HIPPA guidelines that Magellan was using, I spoke with the Director of Magellan’s mental health department, Dr. Rosenberg. Dr. Rosenberg was not familiar with law enforcement, nor was he familiar with Dr. John Violanti who served on the Governor’s Police Suicide Task Force. As a matter of fact, Dr. Rosenberg was a child psychiatrist. This was the person who was making decisions for the officers in the State of New Jersey who were unfortunate enough to have the State Health Benefits Plan.

“When I spoke to him, I pressed him hard for the HIPPA guidelines, and much to my horror two things changed.” First, Dr. Violanti called and confirmed for her -- I won’t read the details -- but he confirmed for her that, yes, 90808 is appropriate treatment for post-traumatic stress disorder, which most of the police officers are coming in to see her for. That’s her specialty. And two, she did get correspondence from Magellan with regard to her request for HIPPA regulations. Magellan sent her a

certified letter requesting an audit of all of her patients. The first line, ironically, reads, “Please be assured that we take patient privacy and confidentiality very seriously.” “This was my response for questioning managed care and advocating for my patients. Several officers left the practice because they no longer felt safe enough to share confidential information. The information that was being asked, they felt, put their job in jeopardy. Several had spouse’s policies that weren’t in the State Health Benefits Plan. So they let the State health policy deny the authorization in coverage and then bill the secondary so that they did not have to give out any confidential information.

“When we refused to give information, letters were sent out saying that we had 45 days to comply. One officer refused to go through the insurance because of these requests made in order to get the authorization. He went on to kill himself several months later. The worst was the officer I mentioned earlier -- Patient X. He was hospitalized, addicted to pain meds. He was going through a divorce, retired, having financial problems. I did everything in my power to explain the situation to care managers. It was clear that a higher level of care was indicated and he would not stay in an in-patient setting longer than committed. He called dozens of times, pleading his case to be rejected. But he was told he should look for an in-network provider. He told them that this wasn’t about a bad knee where anybody could see him. This was about his life, and it was falling apart. The one-time-a-week for 45 minutes wasn’t enough. I told him not to worry about the finances. I saw him for the 75 minutes, even though I wasn’t paid for it. But he was a proud man and really couldn’t accept this. After all, he had been the go-to person who others counted on,

and he didn't want to feel like a fledgling. He finally gave up and stopped coming. I would call him, but the calls wouldn't be answered. It wasn't until last year that I got a call from one of his best friends -- another officer -- who was crying and said that Patient X did it. He killed himself. There were no words for either one of us. His ex-wife left me a long message, which I recorded, wanting to know why there were no provisions for officers to get the help they needed when they had cumulative stressors. The truth is-- 'Why is there no system,' she asked. The truth is, there is a system -- there was a system. It was the State Health Benefits Plan that put managed care in place, which dismantled the original system that worked.

Now, these are her words, "The blood of these officers is on their hands, and God only knows how many others. I am respectfully asking to remove the gatekeepers who prevent patients from getting the treatment they need.

"Respectfully submitted, Stephanie Samuels."

Thank you.

SENATOR GORDON: Thank you very much.

Dr. Axelbank.

J E F F R E Y A X E L B A N K, Psy.D.: Well, I want to thank the Committee for permitting me to offer some insight into the relationship between managed care operators, patients, and providers.

I'm Dr. Jeffrey Axelbank. I'm a psychologist and have been in practice for 21 years, including the last 18 years as a licensed psychologist in private practice. In addition, I'm the Chair of the New Jersey Psychological Association Insurance Committee.

The NJPA, the New Jersey Psychological Association, frequently receives complaints from our members and their patients about insurance company behavior. Due to the increasing number of such complaints, in November 2008 we set up an Insurance Complaint Registry on the Internet where patients and providers could go to describe their experiences with their mental health insurance benefits. To date, we have about 360 entries in the registry. My testimony is based largely on that data, as well as the anecdotal evidence from the complaints we receive via phone or e-mail. In addition, of course, I have my own experiences and problems with managed care operators.

I want to say just generally that the stories we've heard are not only typical, but really the only thing unusual about them is their willingness to come forward and speak up, which is much to be commended but also very rare.

The data from the Insurance Complaint Registry indicates widespread problems ranging from simple things like payment difficulty due to insurance company errors, to truly egregious behavior such as threatening or ridiculing patients -- and we've heard some of that in some of the other testimony. In the material I've given you is a list of the various behaviors reported to our Insurance Complaint Registry.

I want to quote briefly from an article that was in the winter 2013 issue of the New Jersey psychologist journal, as written by Minardo, Rothbaum, Axelbank, and Helfmann, "The Insurance Complaint Registry data confirmed that insurance companies frequently delay or deny authorization of outpatient mental health services, make it difficult for patients and providers to obtain appropriate information, make persistent

errors resulting in payment delays and other problems, and most importantly perform intrusive clinical reviews that require providers to disclose confidential patient information that negatively impacts patients, among other abusive case management practices.”

I want to direct your attention to the pie chart over here. The problems reported in the Insurance Complaint Registry caused moderate distress to patients in about 30 percent of the reports, high distress in almost 37 percent, and extreme distress in more than 21 percent. So that means that in over 88 percent of the complaints registered, the patient was reported to experience at least moderate problems as a result. So to summarize, this data indicates that these policies, tactics, and practices are overwhelmingly hurting patients, and this harm to patients ends up prolonging their treatment.

We’re particularly concerned about the pressure exerted on psychologists and other mental health professionals to violate the confidentiality of our patients. According to the U.S. Surgeon General, “Strong confidentiality laws are critical in creating assurances for individuals seeking mental health treatment and their willingness to participate in treatment to the degree necessary to achieve successful outcomes.” So confidentiality is a cornerstone of effective therapy and is protected by New Jersey law, specifically in the licensing laws and regulations of psychologists and other mental health professionals. However, these laws are regularly disregarded and flouted by the insurance companies.

All insurance companies are required by HIPPA, as well as their own handbooks, to only request the “minimum necessary information” to process claims. The definition of *minimum necessary information* is contained

in the New Jersey psychology licensing law, which lists very specifically what information may be given to insurance companies. Since this law was passed in 1985, it has been the standard for confidentiality of mental health care in New Jersey, and millions -- maybe tens of millions of claims have been processed based on this minimum necessary information.

However, in recent years, insurance companies have asked us to give out more and more information about our patients, beyond what's allowed in the law, as a requirement for authorizing sessions. This puts psychologists in an ethical and legal bind. We can either violate the law and our patients' confidentiality in order to get the benefits for needed care, or we can obey the law and protect confidentiality, but then cause the patient to lose the benefits to which they are entitled. In either case, the patient loses. So we want to emphasize that adequate privacy laws are already on the books here in New Jersey. But insurance companies have been ignoring and violating these laws, and the State has not been enforcing them at all.

SENATOR GORDON: If I could ask a question at this point--

DR. AXELBANK: Sure.

SENATOR GORDON: Is it the Department of Banking and Insurance that's supposed to be enforcing that?

DR. AXELBANK: Well, the Department of Banking and Insurance would regulate commercial insurance. One of the issues is that the State Health Benefits Plan does not come under the Department of Banking and Insurance's jurisdiction. It's the State Health Benefits Commission in the Division of Pensions and Benefits. So, in essence, they

have to regulate themselves. So that's something that could be a legislative fix for -- to have some kind of independent oversight.

SENATOR GORDON: So perhaps we could develop legislation that, just hypothetically, we could shift over to the Attorney General for enforcement.

DR. AXELBANK: That's certainly one possibility, that is in terms of the State Health Benefits Plan. But, of course, there is also commercial insurance companies that are also violating these laws. So if there is one thing this Committee could do it is to act to stop the insurance companies from violating the laws we already have, as well as getting the State of New Jersey to enforce the laws that we already have.

Thank you.

SENATOR GORDON: Excuse me. Do we have leverage over the commercial plans as well, or are we preempted from that?

DR. AXELBANK: Well, over the-- The psychology licensing law stipulates penalties for violating the law, so we have that kind of leverage.

SENATOR GORDON: But the penalties are imposed on the provider, not on the--

DR. AXELBANK: It doesn't say. It just says for any violation of the law.

SENATOR GORDON: Okay.

DR. AXELBANK: And part of what the law says is that not only can providers not provide that information, but the insurance companies can't ask for it. But by asking for it, they're already violating the law.

SENATOR GORDON: Okay.

DR. AXELBANK: I'm certainly open to any questions.

SENATOR GORDON: The data from your registry -- is that summarized in the paper that you referred to?

DR. AXELBANK: Yes.

SENATOR GORDON: Have you submitted that?

DR. AXELBANK: Yes, that's in your packet, as well as-- There is a reference to an article which summarizes, and I can certainly send you a copy of the full article as well.

SENATOR GORDON: Thank you all very much. This has been very helpful. We're beginning to get some direction as to where we can go legislatively, I believe. I appreciate your help with that.

DR. AXELBANK: Thank you.

SENATOR GORDON: I understand I neglected to call up Walter Kalman of the National Association of Social Workers in the last panel. Is he still here?

DR. AXELBANK: I think he left.

SENATOR GORDON: I probably have to mend some fences with him.

DR. AXELBANK: I think he submitted testimony though.

SENATOR GORDON: I would like to bring up, at this point, Don Parker, CEO and President of Carrier Clinic.

Mr. Parker.

D O N A L D J. P A R K E R: Thank you, Senator.

Thank you, by the way, for your persistence in exploring a subject that has enjoyed little legislative popularity over the years. So kudos to you and your staff for your efforts.

I'm going to go right to solutions. You've heard a lot of context today. At Carrier we're not the oldest and largest psychiatric hospital in New Jersey without having solutions for behavioral health issues.

First, I'd like to talk about case rates. Case rates are a potential solution to the horror that you've seen today that a number of patients have endured, as well as the providers -- where we argue it out and substitute one judgement from a clinician for another's. Case rates are negotiated between insurance companies and providers, then are committed to contractual relationships. The State now is entering into a negotiation for a fee-for-service reimbursement for behavioral health. To the extent that we could look at case rates for that, these are evidence-based clinical pathways. It would allow us to negotiate as opposed to argue over this. And then it leaves the clinical judgement to the provider. If we're over or under on the amount of care that we provide, it's our responsibility and our relationship with the patient that takes the prominence in that negotiation.

SENATOR GORDON: Just if I could break in, do we need legislation to require the use of negotiated case rates?

MR. PARKER: I'm not sure what the waiver included, because there is actually a Federal waiver that was filed to allow us to convert to fee-for-service for all the behavioral health that's taking place here in New Jersey through local community mental health centers, etc. If it does, then you should certainly consider it. If it doesn't, and it's an issue that's

decided by the particular department, there ought to be a discussion with the commissioner about focusing on that.

The second item I'd like to raise is the recent developments in genetics. Genetics has the potential to change the entire field of behavioral health in the next decade. Genetic testing can allow us to narrow the field for diagnosis and to actually get precise types of medications and amounts of medications that can be used by patients in their treatment. That takes a lot of the guesswork out of our work, because there is a lot of opportunity for us to further narrow down the amount of time that we take to get the right medication, and then use that work on talk therapy. Talk therapy is an incredibly important part of our treatment regiment today, especially as technology has taken over our daily communication. We're missing the hand on the shoulder, the pat on the back, the firm word, the soft exchange -- all the items that heal all of us in our everyday lives aren't there today. We need to be able to spend more time on talk therapy. That's developing a relationship and influencing a patient through that relationship.

The next item I'd like to talk about is telepsychiatry -- manpower shortage, 27 percent reduction in psychiatry over the last three years in the United States. Over 46 percent of psychiatrists currently practicing today are over 55 years old. That doesn't bode well for us in the future. And without a means such as telepsychiatry, we are going to further diminish our patients' opportunity to get the right care. Ron Dancer has a bill in the Assembly now. We ought to be paying attention to that bill and moving a similar bill in the Senate to approve it. We are one of only 10 states in the country that doesn't have approval for Medicaid reimbursement for telepsychiatry. We need to be able to do that.

Behavioral health -- urgent care. Urgent care is a method for getting patients who are experiencing health problems -- minor and moderate health problems -- out of the emergency room. Right now the only place you can get emergency behavioral health care is in a hospital's emergency room. So what Carrier is now completing is a grant application to the Federal government under the Center for Medicare and Medicaid Services Innovation Grant Series that would allow us to develop a series of urgent care centers across the state that could provide care after hours, weekends, when emergencies actually occur, that don't require appointments. A lot of our patients have a very difficult time keeping appointments, and appointments are never when you're experiencing a need, generally. And you heard from our panel of patients and family members today that to get a follow-up appointment for somebody is a very difficult task and often takes multiple weeks to secure. So to get out of the hospital and not have immediate interaction with your patients is a travesty. Urgent care can achieve that. We'd have to go back with the Department of Health and work on regulatory enabling legislation for that, I believe.

The fourth item I'd like to talk about is the Institute for Mental Disease. That's a 1955 Federal statute that prohibits private psychiatric hospitals from providing care for Medicaid patients who are between the ages of 18 and 65. There is an opportunity to provide -- or to develop a waiver application to the State that would permit private psychiatric hospitals to see Medicaid patients. So right now the only way you get care for a psychiatric issue if you are a Medicaid patient is through a general hospital, that doesn't always have the level of expertise that is required to

handle very difficult patients, or the State hospital system. It would be a benefit to both the general hospital systems, the State hospital system, and patients if that care could be provided in the psychiatric private system as well. Many states have already achieved a waiver. And actually, the State Medicaid directors endorsed a very lengthy opinion that I will provide to you that supports the reduction in that legislative requirement.

SENATOR GORDON: Mr. Parker, where are these private psychiatric units? Are they just subunits of hospitals?

MR. PARKER: Most of the private psychiatric care in New Jersey is offered by hospitals. There are, I believe, six private psychiatric hospitals in New Jersey, all with some type of capacity. And frankly, with a greater degree of sophistication, Carrier, for instance, does 5,000 electric convulsive therapies per year. There is nobody on the East Coast that does that level of care. And it's, frankly, a very effective method with the current improvements in its utilization, and can handle many, many patients who have chronic illness and/or resistance to medication.

And then finally, I'd like to talk about meaningful use. We've heard today the lack of communication between providers. And one of the impediments is the fact that most providers in behavioral health are not connected electronically. You have probably watched over the last several years as the Federal government, and the State government for that matter, has assisted hospitals and physician practices in developing electronic medical records. It doesn't happen in behavioral health.

SENATOR GORDON: We've been trying to do that for 20 years.

MR. PARKER: And we haven't succeeded. I think we need to step it up. The Federal government actually had bipartisan legislation to extend meaningful use to behavioral health in last year's session, and then it was left on the table. I think that support here in the State from our Legislature for that -- and we're asking across the entire country that every state legislature weigh in on this subject so that we get enough support to get Congress to move on it. There is money left in the legislation, so it's not even an additional appropriation. It's use of money that hasn't been claimed by hospitals and physician practices that would allow us to get into the 21st century.

So those are solutions. We're constantly working on them. I think there has actually never been a better time in behavioral health to come up with solutions. Parity is before us. People are paying attention to it. You're having this hearing, and you heard a lot of very brave recipients of care and families who have received care come up and talk about their experience. That hasn't happened consistently in the past.

SENATOR GORDON: Thank you very much, Mr. Parker.

I'd like to just go back to your comments about talk therapy. I thought you said that there isn't enough of it. Is it because the managed care restrictions -- that you can get talk therapy, but no more than *X* number of sessions?

MR. PARKER: It's the most restrictive form of therapy. In fact, I can tell you our psychiatrics spend an average of 49 minutes a day on the phone with utilization review staff from insurance companies trying to get the medication time that we need to get all patients with the right cycle of medication. And then we literally are left with nothing for the talk

therapy side. Carrier has gone, in the last 15 years, from a 28-day average length of stay for substance abuse to 6 days. For behavioral health, we've gone from 30 days to 8.5 days. So that's with no significant changes in the way -- in our technology. So you can see what's left for us. And most of that time is trying to figure out what medication to provide you and stabilize you. And then by that time we're putting you out in the street. And you've heard the horrors from all the patients and family members about what happens when we put you on the street too quick.

SENATOR GORDON: Mr. Parker, thank you very much for some extraordinarily helpful testimony. I want to tell you and others that my intention is to come back and meet with you and do follow-up discussions on this -- a number of you who have been thinking about the legislative side of this -- so that we can address some of the things that are within the power of the State to improve the system.

Thank you.

MR. PARKER: Thank you very much.

SENATOR GORDON: I believe our last witness is Katie Rodebaugh, from HealthCare Assistance.

Are you here, Katie?

KATHLEEN RODEBAUGH: Yes.

Good afternoon.

SENATOR GORDON: Good afternoon.

MS. RODEBAUGH: My name is Katie Rodebaugh, and I've been working in the behavioral health and substance abuse field for over 18 years in all levels of care. I currently work for HealthCare Assistance with Member Support. We advocate for behavioral health, and drug and alcohol

dependency care for professional trade union members across the State of New Jersey. We've been doing this for over 21 years.

Much of my experience has been dedicated to navigating the Bermuda Triangle of clients, case managing, and managed care. All too often I've assessed clients upon admission who have met the medical criteria established by insurance companies, only to be denied the appropriate level of care. I have assessed clients for medical detoxification. And because the physical symptoms -- their vital signs -- were not present at the time of the assessment, they were denied life-saving medical care and only approved for minimal offering of outpatient care.

Managed care companies are denying claims that are deemed medically necessary by physicians and behavioral health professionals. And if they're not denying the treatment, they're committing to a level of care that almost certainly forecasts a drug or alcohol relapse. I have sat across from many clients and their desperate families who met the criteria, needed in-patient treatment, begged for in-patient treatment, and yet I could only get approval for a lesser level of care based on a managed care company deciding what is medically necessary.

Forced to address the emotional instability of the client who is denied proper care, and also console the family members and explain the improper recommendations-- The heartbreak, anger, fear, sorrow; and mostly the misunderstanding from these individuals who would counter with the emphatic statements of their understanding of their own insurance plans-- I know from my years of negotiating care that when managed care is involved, I am often ethically compromised because I know without in-

patient care, that potential client is probably going to relapse, have more negative consequences -- and, in certain cases that I know of, die.

While attempting to get approval for more life-saving in-patient time through managed care, the demands of what needed to happen before the next review were impossible. They would demand psychiatric evaluations, couples counseling, family sessions, to housing upon discharge -- then, denial of care at the last minute with no aftercare set in place. These roadblocks and demands left me feeling overwhelmed, discouraged, and prevented me from truly giving personal care and effective therapy.

If that's how I felt, can you imagine the despair of the family and the client? The hours I spent on the phone trying to obtain medical information and case managing individuals were staggering. Waiting for return phone calls from claim reviewers, then being denied and having to have doctor-to-doctor reviews only to be denied again. The abruptness, the arrogance, the insensitivity of the managed-care reviewers was so frustrating, to say the least.

As a clinician, I got to know the individuals and their families. I was aware of the compromising positions that they were in with an untreated behavioral health condition and/or substance abuse problem. I had the insurance information and what they were entitled to get approved. None of that mattered. The bottom line was that managed care dictated the level of care, the length of stay, and had all the power over the treatment -- not me as the clinician. Medical criteria, treatment plans, external hindrances -- none of that made a difference. My hands were tied, and I was the one who had to sit face-to-face with the struggling individual, having to turn them away from the treatment they so desperately needed.

Insurance is being purchased, policies are outlined in writing, and then the services are denied or diminished. Citizens in New Jersey are relapsing, collapsing, and in many cases dying. It is time for managed care companies to get back into the business of saving lives, not money.

SENATOR GORDON: Thank you very much.

We've heard a lot of compelling testimony today, which makes it clear to me, and I think everyone in this room, that managed care and mental health care are really incompatible. And from what I've heard, this is an opportune time to address a number of these issues to the extent that we can legislatively. I, for one, am committed to trying to do that. As some in this room know, I have had personal experience myself with loved ones who have encountered many of the problems described today. And so I know how it affects a family. Of course, the data shows it affects about 20 percent of New Jerseyans. So this is a big problem. It may be a complex one, but it's something that I think the State really needs to act on. And I'm sure I will have bipartisan support in the Senate and Assembly in trying to get some of these problems fixed.

So I do want to thank everyone who made the effort to be here today and to share some very personal stories. I am confident that we are going to use this information to try to improve the system in New Jersey. So thank you all very much.

I'm going to adjourn the meeting at this point.

(MEETING CONCLUDED)