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|---|---|---|
| **Act Number:** | 09-046 | |
| **Bill Number:** | 46 | |
| **Senate Pages:** | 1091-1108, 1128-1131, 1413-1417, 1479-1481 | **30** |
| **House Pages:** | 3126-3130 | **5** |
| **Committee:** | Insurance: 615-637, 809-821, 823-825, 891, 893-894, 937, 938, 1909 | **47** |
| | **Page Total:** | **82** |

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# CONNECTICUT
# GENERAL ASSEMBLY
# SENATE

## PROCEEDINGS
## 2009

**VOL. 52**
**PART 4**
**1015 - 1350**

Krista D'Amelio, she's a UConn junior and member of the UConn Student Government. And she's been interning for me and I would like circle to give her a nice warm applause.

You can tell she's much more shyer than her father downstairs.

We will turn back to the call of the calendar. Mr. Clerk.

THE CLERK:

Favorable reports, Calendar page 16, Calendar Number 223, File Number 236, substitute for Senate Bill Number 46, AN ACT CONCERNING THE CONSUMER REPORT CARD, favorable report of the Committee on Insurance. Clerk is in possession of one amendment.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. Mr. President, I move for acceptance of the joint committee report and passage of the bill.

THE CHAIR:

Acting on approval, sir, would you like to remark further?

SENATOR CRISCO:

Yes, Mr. President. Mr. President, the Clerk has an amendment, LCO 5303. I ask that be called and I be given permission to summarize the amendment.

THE CHAIR:

Mr. Clerk.

THE CLERK:

LCO 5303, which will be designated Senate Amendment Schedule A. Is offered by Senator Crisco of the 17th district.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. I stated, I move for adoption of this amendment, which is basically a technical amendment that clarifies certain sections of the statute.

THE CHAIR:

Thank you, sir. Will you remark further? Senator Caligiuri.

SENATOR CALIGIURI:

Thank you, Mr. President. If I may, I have a question for the proponent, through you.

THE CHAIR:

Please proceed, sir.

SENATOR CALIGIURI:

Thank you, Mr. President.

It's my understanding that the amendment would effectively create two different definitions of medical loss ratio; the one that's in the bill and the existing definition that would be in the Connecticut General Statutes. And the question for Senator Crisco is, whether he has any concerns with the fact that we would, in effect, have two different definitions of medical loss ratios, now operating under the law, given the amendment and the fact that the amendment would strike out the reference to having the definition apply to those sections of the Connecticut General Statutes that are currently referencing medical loss ratios and which have a definition within it. Through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. Through you to Senator Caligiuri, according to LCO, there will not be any problem. This was an amendment that was recommended by our LCO attorney to make sure that there is no misunderstanding in regards to the definition of

medical loss ratio.

THE CHAIR:

Senator Caligiuri.

SENATOR CALIGIURI:

If I may comment on the amendment, Mr. President. If I may comment on the --

THE CHAIR:

Please proceed, sir, yes.

SENATOR CALIGIURI:

Thank you, Mr. President. I would just note Senator Crisco and I as a ranking member have worked together very well this year that have reached agreement on virtually every bill that's come out of the insurance committee. Unfortunately, this is one where I still cannot agree with the bill. I'm concerned even with the amendment that we're going to end up with two working definitions of the term, "medical loss ratio," and as we move ahead and try to provide information to consumers, I think having two different definitions of the term is neither helpful for the industry, nor for the consumers. And it's for that reason that I will be voting against the amendment, and most likely, the underlying bill. Thank you, Mr. President.

THE CHAIR:

Thank you Senator Caligiuri. Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. I appreciate the remarks of my colleague and ranking member. However according to LCO, the reasons for the amendment, it will avoid the conflict that the very issue that the Senator is referring to. So with the amendment, the technical amendment, it makes it clear which definition an MCO should follow.

THE CHAIR:

Thank you, sir. Senator McKinney.

SENATOR McKINNEY:

Nevermind, Mr. President. I've been here ten years and I'm still pushing the wrong button.

THE CHAIR:

Happens a lot.

SENATOR McKINNEY:

Yeah. Mr. President, actually, the question asked by Senator Caligiuri, I think, is an important one and the answer that Senator Crisco gave raises more questions.

As I understand, through you, Mr. President, to Senator Crisco, Senator Crisco, as I understand it,

the underlying bill states a definition for medical loss ratio. It applies that definition to section 1 and 2 and also to two sections of our General Statutes. This amendment would strike the reference to those two sections of the General Statutes. As I understand what you've read, what you've read is saying the purpose of the amendment is to make sure there's no confusion as to which definition applies, so that the definition in the bill only applies to the bill.

I guess my first question -- well, so what I hear you, then saying, is that the answer to Senator Caligiuri's question is, yes, there are two definitions of medical loss ratio. This amendment clarifies which one we're using for this bill versus the medical loss ratio definition that's currently in our statutes. Through you, Mr. President, is that a correct understanding of the colloquy you've just had?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Yes, Mr. President. Through you, to Senator McKinney, according to our LCO attorney, that is correct.

THE CHAIR:

Senator McKinney.

SENATOR McKINNEY:

Thank you. And so then, the question is, as one who's read this bill at first blush is inclined to support it, the red flag is, why do we have two definitions of medical loss ratio? That doesn't make any sense to me. If I could get an explanation for that, please.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. Mr. President, in speaking with our LCO attorney and members of the insurance industry, it was agreed that the LCO recommendation was correct and that an appropriate -- as an amendment, and as a strictly technical amendment.

THE CHAIR:

Senator McKinney.

SENATOR McKINNEY:

Thank you, Mr. President. Let me start back -- take baby steps. Through you, Mr. President, is it -- am I correct in understanding that in our current law,

this amendment and this bill -- have not become law -- there is a definition for medical loss ratio and that that definition is different than the definition in this underling bill? Through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Yes.

SENATOR McKINNEY:

Okay.

THE CHAIR:

Senator McKinney.

SENATOR McKINNEY:

Then, through you, Mr. President, could I, as one who has never served on Insurance, and that doesn't excuse me from knowing, but less likely to know -- what is the difference between this definition of medical loss ratio and the definition in current statute? My understanding would be that certain things would be included in medical loss ratio in one definition and not the other. And I'm trying to understand why there are different definitions.

I don't -- well, let me go back to the question. What are the differences between his definition of

medical loss ratio and the definition in our current statutes which this amendment deletes as a reference? Through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. Through you to Senator McKinney, again, according to LCO, this avoids the conflict, the very conflict that Senator McKinney is referring to in regards to the definition of medical loss ratio. And by striking these two sections as the amendment does, the conflict is eliminated.

THE CHAIR:

Thank you, Senator Crisco. Senator McKinney.

SENATOR McKINNEY:

A short day might turn into a very, very long one, Mr. President. I'm trying to get a basic answer here, Senator.

I understand that the current bill, as drafted, defines medical loss ratio and references two sections of our statute which also define medical loss ratio, but that those two definitions are different. And so, I certainly get that by offering this amendment, we eliminate the confusion as to which definition we're

using for this bill. I get that. That's not the policy we're going at. That's just a clarification so we don't have a confusing, really confusing law. One would argue that having two statutes with two different definitions of medical loss ratio is still in and of itself somewhat confusing.

My question is, what is the difference between the two definitions? There must be a difference, or we wouldn't have a new one and there must be a reason as to why we have a different definition of medical loss ratio for this statute. And I'm trying to get an answer to that, Mr. President. Through you.

THE CHAIR:

Thank you, sir. Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. And through you, to Senator McKinney, I'd be -- I'm only too happy to accommodate the Republican Leader in regards to this. Basically, as I was advised that we are substituting one definition for another, so we would only have one definition.

THE CHAIR:

Senator McKinney.

SENATOR McKINNEY:

So then through you, Mr. President, is it Senator Crisco's position -- because I actually think, Senator Crisco, that your underlying bill without this amendment would, actually, arguably do that. We have a definition dated today, which would reference previously adopted statutes which has a different definition. I think a good lawyer would say that the latter definition adopted by the Legislature is the definition that prevails. This amendment, which eliminates those statutory references to a prior adopted definition of medical loss ratio doesn't do that. So we would be having two definitions in our statutes of medical loss ratio. And I'm trying to understand what the differences are between the two definitions and what the policy reasons and purpose is behind having two definitions are. Through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President, and to Senator McKinney, my apologies for the circle of not being very clear, but basically, the definition that we are referring to only pertains to the medical loss ratio.

THE CHAIR:

Senator McKinney.

SENATOR McKINNEY:

Thank you, Mr. President. So, through you, Mr. President, what is the difference between the definition we are adopting for purposes of Senate Bill 46, AN ACT CONCERNING THE CONSUMER REPORT CARD, and the definition of medical loss ratio which this legislature has adopted prior? Through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. If we could just be given a few minutes to respond to Senator McKinney.

THE CHAIR:

Yes, sir. The Senate will stand at ease.

Chamber at ease.

THE CHAIR:

The Senate will come back to order. Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. I beg the indulgence of the circle. If Senator McKinney would refer to the File 236, specifically lines 21 to 22; we will have a definition for medical loss ratio as it applies -- as applicable there, but for the managed care contract requirements, and under section 38a-478g, Number 9, there's a definite different medical loss ratio for that part of the statutes.

THE CHAIR:

Senator McKinney.

SENATOR McKINNEY:

Thank you, Mr. President. So I think that's -- we have now confirmed that we have two definitions. If this bill becomes law, we have two definitions between -- for medical loss ratio.

My assumption is that there are certain things that will be included in a medical law -- loss ratio under our existing statute, but we can't. It has to be different ratio. I mean, it's like saying in one section of our statutes, two plus two equals four, and in other sections of our statutes, two plus two equals five, but why? Why do we have a different definition? What is the policy reason for a different definition, and what is the differences in those definitions?

What is included in a medical loss ratio in our existing laws that we find so deficient that we need to change the medical loss ratio definition for this law? And if this is a better definition, why isn't this the definition that controls all? Through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. Through you to Senator McKinney, basically there are two different definitions as applies to our statutes. As I mentioned, in regards to the file and also to section 38a-478g, it is necessary to have two definitions because it applies to two different parts, you know, of the medical loss ratio and two different parts of the statute.

THE CHAIR:

Senator McKinney.

SENATOR McKINNEY:

Thank you, and with all due respect, Mr. President, I'm trying to understand, from the Chairman of the Insurance Committee, as to want the difference is between the definition we're adopting or proposing

to adopt today and the existing definition. I understand there are two definitions. I've read the definition that's in the proposed bill. There is language there that is clearly ambiguous and arguable in court. I don't know what it means. I don't know, for example, Senator Crisco, whether administrative costs are included in this medical loss ratio. I know they're included in -- on existing definition, in our existing statute.

I don't know, for example, Senator Crisco, whether or not prevention programs -- if an insurance company spends money on prevention programs, is that considered an administrative cost, and therefore, not subject to the medical loss ratio in this definition as it is under our current statute? I don't know, Senator Crisco, for example, whether money spent on wellness programs is considered part of the medical loss ratio definition we're proposing now as some argue it is under existing medical loss ratio in our existing statutes.

I'm sorry to be so consistent and persistent. We are -- we have a definition of medical loss ratio in our laws, on our books today. We are proposing to have a separate definition only for this law. Why?

What are the differences? Why are we doing it? If this definition is better, why isn't that the definition that controls all of our laws? I don't get. I'm looking for an answer.

THE CHAIR:

Thank you, sir. Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. I appreciate the concern of the -- of Senator McKinney. Basically if he would read line 20, in File Number 236 which states, parentheses, medical loss ratio means the ratio of incurred claims to earned premiums for the prior calendar year for managed care plans issued in the state. This replaces Number 9 of section 38a-478g, which gives us a better definition of medical loss ratio.

THE CHAIR:

Senator McKinney.

SENATOR McKINNEY:

So therefore, under the current definition of medical -- under the proposed definition of medical loss ratio for this bill, which purports to exclude -- well, the definition of medical loss ratio that's being proposed today excludes from that ratio other

cost containment programs or features. Could we have an understanding of what other cost containment programs or features are? Through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. To Senator McKinney, I was mistaken with regards to lines 20 to 22, replacing Number 9 of 38a-478g. Basically, we do have two definitions and -- which pertain to different parts of the statute.

THE CHAIR:

Senator McKinney.

SENATOR McKINNEY:

I'm sorry, does that mean we have two definitions existing under current law today? Through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Through you, Mr. President to Senator McKinney, the answer is no.

THE CHAIR:

Senator McKinney.

SENATOR McKINNEY:

Thank you, Mr. President. The medical loss ratio, as defined in this bill, in contrast to the existing medical loss ratio, defined in our statutes, which this amendment to its reference to, excludes other cost containment --

THE CHAIR:

Senator Looney -- excuse me, Senator McKinney. Senator Looney, for what purpose do you rise?

SENATOR LOONEY:

(Inaudible.)

THE CHAIR:

Without objection, so ordered. Mr. Clerk.

THE CLERK:

Calendar page 20, Calendar Number 261, file number 291, substitute for Senate Bill 959, AN ACT CONCERNING EXTERNAL APPEALS OF ADVERSE DETERMINATIONS BY A MANAGED CARE ORGANIZATION, HEALTH INSURER OR UTILIZATION REVIEW COMPANY, favorable report of the committee on insurance. Clerk is in possession of an amendment.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Yes. Thank you, Mr. President. Before voting -- calling for a vote on the first consent calendar, Mr. President, would move that all items previously noted for referral to various committees be immediately transmitted to those committees.

THE CHAIR:

Without objection, so ordered, sir.

SENATOR LOONEY:

Thank you, Mr. President. Would now ask the Clerk to call the first consent calendar.

THE CHAIR:

Mr. Clerk, please make a roll call vote for the consent calendar, also.

THE CLERK:

Immediate roll call has been ordered in the Senate. Will all Senators please return to the chamber. Immediate roll call on the consent calendar has been called for in the Senate. Will all Senators please return to the chamber.

Mr. President, those items placed on the first consent calendar began the calendar page one, Calendar Number 364, Senate Joint Resolution Number 73; Calendar 122, Senate Joint Resolution Number 64. Calendar page 2, Calendar 123, Senate Joint Resolution

Number 65; Calendar 124, Senate Joint Resolution Number 66; Calendar 125, Senate Joint Resolution Number 67; Calendar 126, Senate Joint Resolution Number 68. Calendar page 3, Calendar Number 230, House Joint Resolution Number 106; Calendar Number 231, House Joint Resolution Number 107; Calendar 232, House Joint Resolution Number 108. Calendar page 4, Calendar Number 233, House Joint Resolution Number 109; Calendar 234, House Joint Resolution Number 110; Calendar 235, House Joint Resolution Number 111; Calendar 236, House Joint Resolution Number 112; Calendar 308, Senate Resolution Number 14. Calendar page 5, Calendar Number 309, Senate Joint Resolution Number 72; Calendar Number 339, Senate Resolution Number 15; Calendar 340, Senate Resolution Number 16; Calendar Number 387, House Joint Resolution Number 116. Calendar page 7, Calendar Number 105, Senate Bill Number 780. Calendar page 11, Calendar Number 154, substitute for Senate Bill 222; Calendar 157, Senate Bill Number 861. Calendar page 20, Calendar Number 261, substitute for Senate Bill 959; Calendar Number 262, substitute for Senate Bill 960. Calendar page 22, calendar Number 313, Senate Bill Number 947. Calendar page 23,

Calendar Number 315, Senate Bill Number 1012; Calendar 322, substitute for Senate Bill 488. Calendar page 26, Calendar Number 366, substitute for Senate Bill 784. Calendar page 27, Calendar 371, substitute for Senate Bill 243. Calendar page 28, Calendar Number 375, substitute for Senate Bill 1021. Calendar page 29, Calendar 383, substitute for Senate Bill 886.

Mr. President, that completes those items placed on the consent calendar.

THE CHAIR:

Mr. Clerk, could you please call for a roll call vote on the consent calendar again.

THE CLERK:

The Senate is now voting by roll call on the consent calendar. Will all Senators please return to the chamber. The Senate is now voting by roll call on the consent calendar. Will all Senators please return to the chamber.

THE CHAIR:

Have all Senators voted? If all Senators have voted, please check your vote. The machine will be locked. The Clerk will call the tally.

THE CLERK:

Motion is on adoption of Consent Calendar Number 1.

| | |
|---|---|
| Total Number Voting | 36 |
| Those voting Yea | 36 |
| Those voting Nay | 0 |
| Those absent and not voting | 0 |

THE CHAIR:

The consent calendar passes. The Senate will stand at ease.

Chamber at ease.

THE CHAIR:

Senator Looney.

SENATOR LOONEY:

Yes, thank you, Mr. President. Mr. President, the next item we'd like to take up is on Senate Agenda Number 1, previously adopted. That is Emergency Certified House Bill Number 6715. Would ask the Clerk to call that item from Senate Agenda Number 1.

THE CHAIR:

Mr. Clerk.

THE CLERK:

Calling from Senate Agenda Number 1, Emergency

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THE CLERK:

Returning to calendar page 8, where I believe we left off when we were last on matters marked go. Calendar page 8, Calendar Number 223, File Number 236, Substitute for Senate Bill 46, An Act Concerning the Consumer Report Card, favorable report of the Committee on Insurance.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. I move for acceptance of the Joint Committee's favorable report and passage of the bill.

THE CHAIR:

Acting on approval of the bill, sir, would you like to remark further?

SENATOR CRISCO:

Yes, Mr. President. Mr. President, the Clerk has an amendment, LCO 5940, I request the be called and I be given permission to summarize, and I move for it's adoption.

THE CHAIR:

We have an Amendment A on this, Senator Crisco?

SENATOR CRISCO:

Oh, I'm sorry. I'm sorry. Mr. President, since this was a PT'd item, I would like to (inaudible) withdraw LCO 5303.

THE CHAIR:

The motion is on withdrawal of that amendment, 5303. Hearing no objection, so ordered, sir.

And now we're going to call 5940.

SENATOR CRISCO:

Thank you, Mr. President.

THE CLERK:

LCO 5940, which will be designated Senate Amendment Schedule B, is offered by Senator Crisco of the 17th District, et al.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. Mr. President, this was a PT'd item from last week where there was a healthy discussion and corrective, you know, suggestive remarks. Unfortunately due to a drafting error, what was thought to be a technical amendment was not and created other problems. And through the wisdom of this chamber and the leadership of the Senate Majority Leader, we PT'd the item.

Since that time we have reviewed the legislation and have worked with the Department of Insurance and have created Amendment 5940, which rectifies some of the shortcomings of the file copy. Basically it provides more up-to-date information up to the insured, it also requires only one definition and not two definitions. And we also create a more favorable accountability, transparency to those who are interested in the Medical Loss Ratio.

THE CHAIR:

Thank you, sir.

Will you remark further on Senate Amendment B?

If not I will --

Senator Caligiuri.

SENATOR CALIGIURI:

Thank you, Mr. President. Just a question for Senator Crisco, if I may.

THE CHAIR:

Please proceed, sir.

SENATOR CALIGIURI:

Thank you, Mr. President. I -- just for the sake of the record, it's my understanding that this amendment reflects a definition of Medical Loss Ratio that would be used consistent throughout our laws, and

which the department has reviewed and is comfortable with? Through you to Senator Crisco.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. Mr. President, through you to Senator Caligiuri, that is correct.

THE CHAIR:

Senator Caligiuri.

SENATOR CALIGIURI:

Thank you, Mr. President. I intend to support the amendment and the underlying bill, and I thank Senator Crisco for his work on it.

THE CHAIR:

Thank you, sir.

Will you remark further on Senate Amendment B?

If not, I will try your minds. All those in favor please signify by saying aye.

VOICES:

Aye.

THE CHAIR:

The nos, nay.

The ayes have it, Amendment B passes.

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. As I alluded to some specific changes the amendment contained, this really provides more up-to-date information to the consumer upon request by changing the various dates to make it more timely. We have one definite definition for Medical Loss Ratio and we made sure we had dotted every "i" and look forward to the circle adopting this bill.

THE CHAIR:

Thank you, sir.

Will you remark further on Senate Bill 46 as amended by Senate B? Will you remark further?

Senator Crisco.

SENATOR CRISCO:

Mr. President, if there's no objection I request that this be placed on the Consent Calendar.

THE CHAIR:

There's a motion on the floor for consent. Seeing no objection, so ordered, sir.

Mr. Clerk.

THE CLERK:

Calendar page 12, Calendar Number 264, File Number 303, Substitute for Senate Bill 1023, An Act

Agenda Number 3, Emergency Certified Bill 6716 and House Bill -- correction, 6379.

Turning to the calendar, calendar page 2, Calendar Number 475, Senate Resolution Number 19; Calendar 476, Senate Resolution Number 20; Calendar 477, Senate Joint Resolution Number 74.

Calendar page 4, Calendar Number 139, Senate Bill 854.

Calendar page 6, Calendar 178, Senate Bill 873.

Calendar page 7, Calendar 194, Substitute for Senate Bill 756.

Calendar page 8, Calendar 223, Substitute for Senate Bill 46.

Calendar page 10, Calendar Number 240, House Bill Number 6401.

Calendar page 12, Calendar Number 264, Substitute for Senate Bill 1023.

Calendar page 14, Calendar 328, Substitute for Senate Bill 814.

Calendar page 19, Calendar Number 400, House Bill 6351.

Calendar page 20, Calendar Number 402, Substitute for House Bill 6193.

Calendar page 21, Calendar 408, House Bill 6322;

Calendar 409, Senate Bill 1013.

Calendar page 23, Calendar 423, Substitute for Senate Bill 1010.

Calendar page 27, Calendar 443, Substitute Senate Bill 1149; Calendar 447, Senate Bill 673; Calendar 448, Senate Bill 1029.

Calendar page 30, Calendar 459, House Bill 5138; Calendar 461, House Bill 6406; Calendar 462, Substitute for House Bill 6537.

Calendar page 39, Calendar Number 81, Substitute for Senate Bill 760; Calendar 83, Senate Bill 762; Calendar 99, Senate Bill 787.

Calendar page 40, Calendar 119, Substitute for Senate Bill 778.

Calendar page 43, Calendar 171, Senate Bill 251.

Calendar page 46, Calendar Number 266, Senate Bill Number 382.

Calendar page 51, Calendar Number 356. SB855

Mr. President, I believe that completes those items previously placed on the first Consent Calendar.

The Senate is now voting by roll call on the Consent Calendar, will all Senators please return to the chamber. The Senate is now voting by roll call on the Consent Calendar, will all Senators please return

to the chamber.

THE CHAIR:

The machine is open.

Members, please check the board to see if your vote is properly cast and properly recorded. If all members have voted, the machine will be locked.

Would the Clerk please take a tally.

THE CLERK:

Motion is on adoption of Consent Calendar Number 1. Total number voting, 35; those voting yea, 35; those voting nay, 0; those absent/not voting, 1.

THE CHAIR:

Consent Calendar 1 is passed.

Senator Looney.

SENATOR LOONEY:

Yes. Thank you, Mr. President. Mr. President, the two items that appeared on Senate Agenda Number 3, have just been passed on the Consent Calendar. I would move that the first item from Senate Agenda Number 3, House Bill 6716, the emergency certified bill, I move for immediate transmittal of that item to the Governor.

THE CHAIR:

Motion is for immediate transmittal to the

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Those voting Nay 0

Those absent and not voting 10

SPEAKER DONOVAN:

The bill as amended is passed.

Will the Clerk please call Calendar Number 533.

THE CLERK:

On page 21, Calendar 533, substitute for Senate Bill Number 46, AN ACT CONCERNING THE CONSUMER REPORT CARD, favorable report of the Committee on Insurance and Real Estate.

SPEAKER DONOVAN:

Representative Fontana.

REP. FONTANA (87th):

Thank you, Mr. Speaker. Mr. Speaker, I move for acceptance of the joint committee's favorable report and passage of the bill in concurrence with the Senate.

SPEAKER DONOVAN:

The question is on acceptance of the joint committee's favorable report and passage of the bill. Will you remark?

REP. FONTANA (87th):

Thank you, Mr. Speaker. Mr. Speaker, this bill clarifies and improves and expands upon the so-called

consumer report card prepared by Department of Insurance each year. Specifically, Mr. Speaker, this bill one, requires that the insurance Commissioner include in the annual health insurance consumer report card the medical loss ratio of each insurer and HMO the report discusses; two, that the insurance department prominently display a link to the report card on its website; and three, that each health insurer or HMO disclose its medical loss ratio in writing to a person when he or she applies for coverage.

The bill also renames the report card a comparison guide all HMOs in the 15 largest insurers that offer managed care plans in Connecticut, the consumer report card on health insurance carriers in Connecticut and makes various technical changes.

Mr. Speaker, the Clerk has an amendment, LCO 5940. I ask that he call it and that I receive permission to summarize.

SPEAKER DONOVAN:

Will the Clerk please call LCO 5940, which is designated Senate B.

THE CLERK:

LCO number 5940, Senate B offered by Senator

Williams, et al.

SPEAKER DONOVAN:

The Representative seeks leave of the chamber to summarize the amendment. Is there objection? Representative Fontana, you may proceed with summarization.

REP. FONTANA (87th):

Thank you, Mr. Speaker. Mr. Speaker, this amendment one, clarifies the definition of medical loss ratio in the laws requiring a managed care organization to give certain information to the insurance Commissioner and the plan enrollees; two, changes the deadlines for distribution of the report card and for managed care organizations to submit their information; and three, makes other technical changes. I move for its adoption.

SPEAKER DONOVAN:

The question before the chamber is adoption of Senate Amendment Schedule B. Will you remark on the amendment. Remark on the amendment? If not, let me try your minds. All those in favor of the amendment, please signify by saying, aye.

REPRESENTATIVES:

Aye.

SPEAKER DONOVAN:

All those opposed, nay.

The ayes have it. The amendment is adopted.

Remark further on the bill as amended? Remark further on the bill? Representative D'Amelio.

REP. D'AMELIO (71st):

Thank you, Mr. Speaker and good afternoon to you. I rise in support of this bill as amended. This is a product that -- this bill is the product of a lot of work that went back and forth between the industry and our leadership on the Insurance Committee. And I urge adoption. Thank you.

SPEAKER DONOVAN:

Thank you, Representative. Will you remark further on the bill as amended? Will you remark further on the bill as amended? If not, staff and guests come to the will of the House. Members take their seats. The machine will be open.

THE CLERK:

The House of Representatives is voting by roll call. Members to the chamber. The House is voting by roll call. Members to the chamber, please.

SPEAKER DONOVAN:

Have all the members voted? Have all the members

voted? Have all the members voted? Please check the board to make sure your vote has been properly cast. If of the members have voted, the machine will be locked and the Clerk will take -- please take a tally. Will the Clerk please announce the tally.

THE CLERK:

Senate bill 46 as amended by Senate B in concurrence with the Senate.

| | |
|---|---|
| Total Number Voting | 142 |
| Necessary for Passage | 72 |
| Those voting Yea | 142 |
| Those voting Nay | 0 |
| Those absent and not voting | 9 |

SPEAKER DONOVAN:

Bill is passed in concurrence with the Senate.

Are there any announcements or introductions? Representative Gibbons.

REP. GIBBONS (150th):

Mr. Speaker, I rise for the purpose of an introduction, if I may, please.

SPEAKER DONOVAN:

Please proceed, madam.

REP. GIBBONS (150th):

Thank you. Ladies and gentlemen of the chamber,

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All right. Having said that, we will proceed now to the first bill on the agenda, Senate Bill 46. And the first person we have signed up to testify is Gretchen Vivier. Yes. Okay. Gretchen Vivier to be followed by Rich Sivel of AFSCME.

So Gretchen, welcome and please proceed.

GRETCHEN VIVIER: Oh boy. Okay. Hi. Good afternoon, Senator Crisco, Representative Fontana, and any other committee members. My name is Gretchen Vivier. I'm the health-care organizer at the Connecticut Chapter of the National Association of Social Workers. And at this time I'm here to support Proposed Bill Number 46, An Act Concerning Transparency of Medical Loss Ratio Information.

With all the people suffering due to the lack of quality, affordable health-care, we need to do all we can to spend our health care dollars as wisely as possible. Transparency of the numbers that go into the medical loss ratio will give us some of the information we need in order to do that; then we'll know just how much is spent in processing claims and managing chronic disease as opposed to marketing and executive salaries. Then a judgment can be made as to whether we really believe that is the best way to spend our health care dollars. Some may say that we really need to focus on the -- 80 to 90 percent that is actually spent on health care. Whether or not it is spent in the most efficient manner is obviously important; however, at least that money is going to health care.

We also need to control the money that is not

getting anyone any health care. To put this into perspective, let's look at the salary of one insurance company executive in this state. His $25 million he made in one year could have ensured 2,000 families in Connecticut or put over 100 doctors through medical school.

So we do urge you to pass this bill out of committee and perhaps to go even further and to set a limit on what the medical loss ratio can be. I don't really know for sure what that number -- I think some other states are in the 85 to 90 percent area. And certainly with Medicaid coming in with 3 percent of medical costs, we could do a lot better. Thank you.

REP. FONTANA: Thank you, Gretchen, and certainly accountability and transparency are some of the hallmarks or keywords of this legislative session, so that's certainly something we should be looking at, and I can tell you there will be another on accountability and transparency that we'll be hearing probably in the next week or so.

GRETCHEN VIVIER: Good.

REP. FONTANA: So you'll have another opportunity, as well. Are there questions from members of the committee for Gretchen? Seeing none, thank you.

GRETCHEN VIVIER: Thank you.

REP. FONTANA: Before I ask Rich Sivel of AFSCME to come up, if he's here, I just want to mention for the record that there are a number of members of the committee who may be in the process of committee meetings or public hearings elsewhere so you may see people

coming in and out. It's not that they don't want to be here. It's that they have other commitments that preclude them from being here continuously or may call them away for other reasons. And is it Rich Sivel -- Sivel from AFSCME here? All right. Seeing not, is Bill Shortell here?

BILL SHORTELL: Right here.

REP. FONTANA: Very good. Please step up, Bill.

BILL SHORTELL: I'm Bill Shortell. I'm from the machinists union. I'm also the Chair of the AFL-CIO Universal Health-Care Committee. SB46

Two weeks ago, 57 people in Pratt & Whitney in East Hartford got laid off, lost their health insurance. These same people are going to be looking at their mortgage payments and looking at their health care bills and trying to decide which ones they're going to take care of.

Health care in the United States is the most expensive in the world, twice as much as on the average in other industrial countries. Administrative costs of the insurance companies take anywhere from 6 percent to 26 percent of premiums and tax dollars devoted to health insurance. That's by the congressional budget office.

The 6 percent is for large pools with a thousand or more people in them. The 26 percent is the little ones that have dozens or hundreds in their pools, like for instance, small municipalities in the state of Connecticut.

As you can probably see, I'm leading to

putting two ideas together. You all passed last year, and I'm grateful for that, a pooling bill to open up the state employees health insurance pool to municipalities and small businesses.

The Governor, in her -- she made a mistake in vetoing this bill. She did say however that she was going to work with you in putting it together for this year, and these two issues go together. We need to tell the insurance companies, we need to tell municipalities, we need to give an opportunity for small businesses to get into a large pool that will have low costs, and then we need to cap the administrative costs.

I don't really like the term "medical loss ratio". It's upside down. It should be administrative costs transparency is what we're looking for. And that's how I'm going to explain it to my members when I try to get them to lobby for this bill.

REP. FONTANA: Thank you. That was the three minutes. Let me just stop you right there.

You raised a good point about how it is we term this loss ratio, and maybe it is flipped around, but we will be having a public hearing later on this month on the bill from last year, the health-care pooling arrangement so we will have an opportunity to see you again in that context, and like I said, we may have other proposals trying to promote additional transparency when it comes to administrative costs. So thank you.

Are there questions for Bill from members of the committee? Seeing none, thank you, Bill, very much.

Phil Sherwood, if Phil is here.

PHIL SHERWOOD: Good afternoon.

REP. FONTANA: Good afternoon.

PHIL SHERWOOD: Representative Fontana, Senator Crisco, other members of the committee, thank you. My name is Phil Sherwood. I'm the deputy director of the Connecticut Citizen Action Group. CCAG has approximately 25,000 members and currently is one of the state's oldest public interest groups. And we'd like to express strong organizational support for Senate Bill 46, An Act Concerning Transparency of Medical Loss Ratio Information.

We support the efforts behind this legislation that aim to increase and provide transparency for consumers by requiring the disclosure of medical loss ratios of a particular company and/or organization. We believe that in an effort to increase competition and efficiency in the health-care system, that there be a minimum medical loss ratio established as well. Setting these basic standards will guard against wasteful administrative costs, excessive profits and ultimately protects consumers.

Specifically, with insurers, it's important that the state set these benchmarks that require insurers to spend at least, we would say, 87 and a half percent of the premium dollars on medical care. Now more than ever it's vital that the public and policymakers are provided with this information that demonstrates how much the insurer is actually spending on administration, marketing, and of course, profit.

Setting this minimum medical loss ratio encourages efficiencies and competitions, two things I think we argue that are sorely needed if we're going to grapple with rising cost of health care premiums. Other states currently do do this, and those states have found that they're in a better position to control the skyrocketing costs of premiums. And when an insurer exceeds this minimum medical loss ratio, we would argue that refunds be provided to the policymakers and that perhaps they even be fined by the state.

And in closing I have more to say, but I would like to thank this committee for taking this issue seriously. Transparency in this regards will only help us reduce the cost of health care.

REP. FONTANA: Thank you, Phil, and just to give you an opportunity for us to expand, in my -- in your answer to my question, you and Gretchen Vivier both mentioned what other states do, and in terms of trying to set benchmarks, is there a particular basis for that 87 and a half percent that you support? I mean is that based on something?

PHIL SHERWOOD: California recently floated a minimum medical loss ratio bill. I believe it was in the area of 85 percent.

Most states are anywhere from 67 to 75 percent. In my testimony that I actually don't have with me now, but should be with you guys, on the backside of it, are some of the percentages that other states currently require, and it's not always the same from market to market. There's different benchmarks to be met for obvious reasons.

But the transparency that this bill aims at is very important as well.

REP. FONTANA: Okay. Great. Because that was just one of the things that has troubled me, as I think that we do want to get that transparency out there. We do want to give those competitive forces an opportunity to work, but if they don't succeed, we may want to consider pursuing benchmarks. And at that point, then we'd want to have a rational basis for trying to set a benchmark that actually makes sense, so I think that, you know, some of your testimony is actually helpful in that regard because, as you're indicating, other states have chosen to go that route to try to get a little better performance.

PHIL SHERWOOD: Yeah, and there are -- there is data compiled by Families USA that show that those states that have enacted this have been better positioned to control the skyrocketing premiums that consumers are being hit with.

REP. FONTANA: Great. Well, if you or Bill or somebody could perhaps send us to the link or the URL, to that Family USA research, I would be happy to see that. Thank you.

PHIL SHERWOOD: Will do.

REP. FONTANA: Are there questions for Phil from members of the committee? Representative O'Connor.

REP. O'CONNOR: Thank you, Mr. Chairman. Thank you, Phil, for your testimony. Just a follow-up on Chairman Fontana's point. What study or what information have you used as a basis for this information? Has California or

some of the other states -- have they seen a percentage of their uninsured go down, or has their increase in premium cost or the cost of health care, you know, a lesser percentage than the state of Connecticut?

PHIL SHERWOOD: Yeah, the data I've seen, and that's through Families USA, and I'd be happy to forward that to you, shows that after enacting this minimal medical loss ratio, that on average the increases in premiums have been less than states who haven't acted and also less than the increases in premiums in that same state before they enacted it.

It's not a silver bullet, but that, you know, when you're comparing apples and oranges, states that have it and don't have it, it jumps out as having them in a better position.

REP. O'CONNOR: And these other states, you say that there's a percentage, let's say one of them is 12 and a half, or what you recommend that was 12 and a half, California is 15 percent. Or I guess we should flip it around -- 85 percent or 87 and a half. Do they have -- I mean, what's their definition of the medical loss ratio? What's included? What's not included? Would you include reinsurance costs, nursing, you know, costs? Would that be a health-care cost, you know, their salary?

PHIL SHERWOOD: Every state, Representative, every state is different so that's why it's a little difficult. You can make an argument that one state setting a rate of 67 percent is better than some states that have it at 77 percent based on how they define what a medical loss ratio is.

What constitutes, you know, direct health-care costs. That's something that's in the -- devil is in the details. We would be interested in working, but that made it difficult for them to compare apples and oranges.

REP. O'CONNOR: And then just one final question, Mr. Chairman. How is this information released? Is it a part of -- I guess, would you envision it as part of the report card that goes out by the managed care companies, or would it be available online either on the company's website or would it be at the State DOI website?

PHIL SHERWOOD: We would like to see it reported to the Department of Insurance, but I think we would be open to other ideas. What we would want ultimately is transparency.

REP. O'CONNOR: Okay. Thank you very much, Mr. Chairman.

REP. FONTANA: You're welcome. Other questions for Phil from members of the committee? Seeing none, thank you, Phil.

PHIL SHERWOOD: Thank you.

REP. FONTANA: And for those of you who have just come in, again we've got a few seats up to either side of us here towards the end. So if you're standing for any reason, feel free to try to raid some of those seats that are available.

Next, I've got Ken Ferrucci followed by Karen Schuessler.

KEN FERRUCCI: Good afternoon Senator Crisco, SB46

Representative Fontana and, members of the Insurance and Real Estate Committee. My name is Ken Ferrucci. I'm the vice president of Public Policy and government affairs for the Connecticut State Medical Society, and thank you for the opportunity to testify before you today.

You may recall last week, I did come before you on a similar bill that would require the publishing of the medical loss ratio for health insurers in the consumer report card that the Department of Insurance releases annually. I did state then that I'd come back before you today with some suggestions and recommendations that we feel are necessary to make the disclosure of a medical loss ratio more transparent and give it more impact for its usefulness to consumers.

What I have included in my testimony today is, first of all, Representative Fontana, to answer one of your questions from last week is there are currently 15 states that in some way require there to be disclosure or limitation on medical loss ratios. Also, what we'd like to see amended into this bill is currently state statute defines loss ratio as incurred claims to earned premiums by the numbers of, you know, the policy duration for all combined durations.

We suggest changing the definition to mean that the total number of medical expenses divided by total premiums and subsequently defined medical expenses, premiums and administrative costs. We would recommend defining medical expenses as a total amount of money that an insurer spends on direct medical care services for enrollees. This would include the total financial obligation for

physician services, nonphysician health care professional services, hospital and other health care facilities' services, drugs and medical services and other health-care services that health insurers incur on behalf of its enrollees.

Regarding administrative costs, we would like them to include, but not be limited to, costs associated with claims processing, collection of premiums, marketing, operations, taxes, general overhead, salaries and benefits, quality assurance, utilization review and management, pharmacy and other benefit management, network contracting and management and state and federal regulatory compliance.

Then when you do define premiums, that could be defined as the amount the purchaser pays to the health care insurer for the purchase of health-care cost coverage. I think by expanding the definition of medical loss ratio and being more specific about what's included in the medical costs, administrative costs, would allow employers and consumers to more adequately compare the policies that they're potentially purchasing and have a better understanding of what it is that they are getting for their dollar. Thank you.

REP. FONTANA: Thank you, Ken, and I just fished out your testimony so I'll make sure I read it over for all those detailed suggestions you've got.

Are there questions for Ken from members of the committee? Seeing none, thank you, Ken. Appreciate it.

KEN FERRUCCI: Thank you.

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REP. FONTANA: Next -- again, Karen Schuessler followed by Dr. Steve -- I'm sorry, Dr. Steve. I can't do your last name justice so hopefully Dr. Steve is here. Karen, please.

KAREN SCHUESSLER: Hi, my name is Karen Schuessler. I'm the director of Citizens For Economic Opportunity, which is a coalition of community and labor groups adjusting health care reform and corporate responsibility, and I strongly support SB 46. Establishing greater transparency regarding the medical loss ratio is a giant step in making the health care system more efficient and ensuring that all Connecticut residents have health care that is affordable and accessible.

Now, transparency of a medical loss ratio is important for many reasons, including the following: The United States spends $350 billion a year on administration and paperwork; health care premiums in Connecticut rose 8.2 times, faster than median endings from 2000 to 2007; and CEO pay for insurance companies is excessive and extravagant. Ronald Williams, the CEO of Aetna made $23,045,834 in total compensation in 2007.

And some insurance companies value profits at the expense of policyholders and for too many insurance companies -- and the name of the game is deny, delay and defend to avoid paying claims. And unless you're here in Connecticut, Assurant Health denied hundreds of claims alleging that patients have health problems that predated their policies. The Connecticut Insurance Department had an outside firm reexamine 811 claims, and a settlement was reached and Assurant companies paid more than $25,000 in restitution and interest on 39 previously denied health

insurance claims.

So establishing transparency is important, but it's only the beginning, and I urge you to go a step further and support a medical loss ratio of no less than 87.5 percent. And if an insurer fails to spend enough on medical care to meet the minimum medical loss ratio, it must either refund consumers or adjust their premiums.

And as we heard here today, a number of states are implementing medical loss ratios to reduce excessive profits. New Jersey requires individual and small-group insurers to spend 75 percent of the premium dollars on medical care, and at the beginning of the year, they file a certification that medical claims will exceed 75 percent of premiums. And this has resulted in $11.6 million being refunded to consumers between 1993 and 2006.

And other states refunded money to policyholders. As a result, Maine's medical loss ratio -- one Maine insurance company refunded policyholders 6.6 million and another one refunded policyholder's 1 million. And in May of 2008, it was announced in New York, the governor and the Department of Insurance that Oxford Health Insurance would refund $50 million to 37,000 small businesses in the state because they did not achieve the 75 percent minimum medical loss ratio.

So while I appreciate your efforts to make health care more efficient and urge your support of this bill, I hope you will go a step further and adopt a medical loss ratio of no less than 87.5 percent, which would result in money being refunded to policyholders and may increase doctors' reimbursements. Thank

you.

REP. FONTANA: Thank you, Karen, for your testimony. Again, we'll look forward to getting whatever information you have on that 87.5 number and the reason for it and what other states do. That would be helpful.

Questions for Karen from members of the committee? Senator Caligiuri.

SENATOR CALIGIURI: Thank you, Mr. Chairman. Thank you for testifying today.

Just a quick question. When I think about this issue, one of the issues that I'm currently struggling with is how to define administrative expense, you know, which would be a big -- an important component of what constitutes medical loss ratio. Do you have a sense of how to define that, how it's been defined in other places?

The reason I raise that is because I'm concerned that some of the activities that a health insurer might be engaging in to encourage wellness and that sort of thing not get swept into that part of the calculation. And I'm sorry if I missed --

KAREN SCHUESSLER: It would have to be determined -- no. But I think, as Phil Sherwood said earlier, it's kind of all over the place for different states, but I know a lot of it is for marketing, the costs of underwriting is part of administrative -- that's how I've seen it defined in a lot of places, but that's all over the place. But you're right, those factors have to be considered as to --

SENATOR CALIGIURI: But as a matter of principle, would you agree that activities engaged in that are intended to encourage wellness and that sort of thing probably shouldn't be included within the scope of an administrative expense.

KAREN SCHUESSLER: Uh-huh.

SENATOR CALIGIURI: Okay. Thank you very much.

Thank you, Mr. Chairman.

REP. FONTANA: Thank you, Senator.

Other questions?

Seeing none, Karen, thank you. Again -- oh, sorry, Dr. Steve Thornquist followed by Christine Cappiello.

A VOICE: (Inaudible).

REP. FONTANA: Very good, we'll look forward to seeing Dr. Thornquist later on.

Is Christine Cappiello here? Yes, she is. Okay.

Welcome.

CHRISTINE CAPPIELLO: Good afternoon, Senator Crisco, Representative Fontana, members of the Insurance and Real Estate Committee. For the record, my name is Christine Cappiello, I'm the director of government relations for Anthem Blue Cross Blue Shield and I'm here today to speak on Senate Bill 46, An Act Concerning Transparency of Medical Loss Ratio

Information.

We are opposed to this legislation because we believe that consumers having this information will only serve to confuse them rather than help them, and we also believe that this bill will create an anticompetitive nature among insurance carriers.

Medical loss ratio is a metric that bears little relationship to the quality of a health insurance product and should not be used by consumers as an indicator of value. We are concerned because this will be confusing to consumers because it is not to be used in the first place as an indicator of a value of an insurance product. It's especially misleading if it happens to get into a situation of a product-by-product basis, which has happened in California, and it is because smaller pools are less stable than larger pools and insurers often pool those risks and cross subsidize the medical risks.

So in any given year one product may experience a high MLR while another product experiences a rather low one. We also believe that anticompetitive -- and that's in my legislation. It's in my testimony as well. And so in the interest of time we ask the committee respectfully not to move forward.

REP. FONTANA: Thank you Christine, just one question. I can understand your point vis-a-vis comparing large pool administrative expenses or medical loss ratios to small pool, but comparing apples to apples by allowing a company to compare the medical loss ratios for their pool based on a provider, that doesn't seem to be as much of a problem, does it?

CHRISTINE CAPPIELLO: Well, I think part of the issue is that you may have, for instance, there are some companies that take all their medium-size business, which would be that 100 to 500 marketplace, and they pool them all together in terms of risk, and some groups within there have a good year and some groups have a bad year. So you're not seeing the true image of that one group.

And the reason for that is that's who you spread the risk and it helps the premium so that there is a big shift in premiums because the smoker market is the only one that has those bans with the premiums. So that's where even within that medium -- those medium-sized groups, you may -- you're not seeing the true MLR for that group, you're seeing the average and you also have to understand that you may have a bad year and the next year may be a good year.

So for the consumer maybe they look at it and it's the bad year but that's only -- it's only one little snapshot in time, and that's why we think it's going to be confusing for consumers. It doesn't tell a whole -- it's hard to tell a whole story with just that, that metric, which also gets back to what you define as administrative costs as well.

I also want to say that, you know, I think previous speakers maybe have led people to believe that this isn't disclosed to the Department of Insurance, it is disclosed, and in fact actually for fully insured business it's in there. Members get it on their certificate of coverage so there is some disclosure that's already occurring.

REP. FONTANA: Thank you, Christine. So this information is disclosed to the Department?

CHRISTINE CAPPIELLO: Yes.

REP. FONTANA: And you're saying that it's a confusing or nonproductive thing to disclose to others?

CHRISTINE CAPPIELLO: It's disclosed to the consumers under their -- if they are a fully insured business under their certificates of coverage. So once you become a member of Anthem and you get the big booklet with all the stuff in it, it is disclosed in there. And that was maybe an average of, like I said, if you're in those medium-sized groups, but it is disclosed to the consumer. I think the question is when you're looking at it at a point of sale, you're looking at it as your -- you know, you're looking, the Signa, the Aetna -- okay.

REP. FONTANA: Sorry, let me reframe my question, if I could.

CHRISTINE CAPPIELLO: That's okay.

REP. FONTANA: Let's say there is a company with 100 lives, covered lives.

CHRISTINE CAPPIELLO: Okay.

REP. FONTANA: And they are with one of your competitors.

CHRISTINE CAPPIELLO: Uh-huh.

REP. FONTANA: And they want to come to you.

CHRISTINE CAPPIELLO: Uh-huh.

REP. FONTANA: But all they know is the medical loss ratio of the company that they currently have. How could they find out your medical loss ratio because that's really what's important to them if they want to think about switching to you instead of their current company?

CHRISTINE CAPPIELLO: Well, what would happen in that situation is that if we're the prospective carrier, we would request from the current carrier -- or actually from the administrator, from the group itself, their claims experience, and that's how we derive the premium. Because I think what's going to end up happening is that employer is going to want to understand what his premium is going to be, and so the only way that you're going to be able to look at that is the claims experience. So just looking at a general MLR number isn't going to necessarily tell that potential employer everything he wants to know. He's going to want to know what the premium is.

hat's really what's going to drive a lot of his decisions, and he's going to want to know what gets covered -- what will you cover for me as the new carrier in terms of obviously benefits but also what are some of your disease management programs, what are some of your -- the automated claims system and how fast you pay providers, your provider rate, your provider network, all those sort of things. Those are the things that purchasers of insurance really want to know. Just having an MLR there is sort of just -- it doesn't tell the whole story. It's not going to tell all those things for a purchaser of insurance,

whether it's an individual or whether it's a group -- an employer.

REP. FONTANA: Okay. Are there questions for Christine?

Senator Caligiuri.

SENATOR CALIGIURI: Thank you, Mr. Chairman.

Christine, you mentioned MLR is not the best way for a consumer to understand the value that he or she would be getting from an insurance product. Is there a better way? I know you just mentioned a number of variables that may be a better metric for value. But is there a way of putting that together and giving consumers a better sense of what value they get from one plan as opposed to another?

CHRISTINE CAPPIELLO: I don't know that there is a one sort of measurement. I think you'd have to -- and it is confusing, there is no question about it. I think that's where brokers become very helpful because they know the difference in each company and the innovation in each company and what they spend their money on, you know, in technology and all the rest of it, and there's all very important things for the purchasers to understand and to know. I don't think there is one -- not that I can think of. And I know legislatures have struggled with it and certainly departments of insurance have struggled with it.

SENATOR CALIGIURI: And speaking only for myself, I ask only because to the extent that this is about helping consumers better understand value and compare value, if there were an

alternative way of doing it, speaking only for myself, I'd be very open to some ideas on what that would be.

CHRISTINE CAPPIELLO: Okay.

SENATOR CALIGIURI: Thank you, Christine.

Thank you Mr. Chairman.

REP. FONTANA: You're welcome, Senator.

Other questions for Christine from members of the committee?

I too would be interested in any other methods you can recommend for how people can compare, but thank you for your testimony.

CHRISTINE CAPPIELLO: Absolutely.

REP. FONTANA: Thank you. And that completes the testimony that we've got for Senate Bill 46.

We'll move on to House Bill 6277. And before we do, I just want to alert the people who are here that we have established or are establishing a so-called overflow room where people can hear or perhaps even see the testimony and the committee process, room 1B downstairs next to the cafeteria. So if it turns out that there are people looking for seats and they can't find them, please alert them to the possibility of going down to room 1B to hear and possibly see what we're doing as well.

Okay, with that we'll -- is Rich Sivel here? Okay, very good, Rich, then please -- we weren't sure you were here. Welcome.

RICHARD SIVEL: Good afternoon cochairs Crisco and Fontana. I apologize for not being here earlier. I ran into some traffic problems on the way.

My name is Rich Sivel. I'm a health care organizer with AFSCME Council 4. I live in West Hartford and I also wanted to point out that before I got involved in the nonprofit and labor world, I spent about 25 years doing financial IT systems for the insurance industry. I'm here to testify in support of Senate Bill 46. We represent more than 35,000 workers in public service. We strongly support the bill's intent to require health insurers to report to consumers before they sign on the dotted line the percentage spent on patients in medical care versus administrative costs and profits.

We also should go further in the bill to give consumers information to effectively compare plans and get maximum value for their health dollar. This starts with ensuring that the legislation includes a better definition of medical loss ratio as others have mentioned already. We should limit the insurance industry's ability to mask their costs and gain the system by requiring them to accurately report all non medical costs. Some steps we could take are insurance subcontractor, administrative costs should be reported as administration and not care, investment and other income should be used to calculate loss ratio, not just premiums, and finally loss ratio should be provided for each line of business and health benefit plan, not aggregated across all product lines.

The legislation should also go further to

protect consumers, including but not limited to establishing a minimum medical loss ratio using public insurance as the reference, requiring insurers to provide refunds to consumers if they exceed maximum threshold, providing much more transparency for consumers and establishing better rules on how private insurance industry makes coverage decisions and sets rates and making available claims and outcomes data.

REP. FONTANA: Rich, thank you, the buzzer went off.

RICHARD SIVEL: Okay, thank you. You've got my written testimony. I've got references in there. Thank you very much.

REP. FONTANA: Thank you, Rich. We're glad that you made it.

Are there questions for Rich from members of the committee? Seeing none, thank you very much, Rich.

RICHARD SIVEL: Thank you.

REP. FONTANA: Appreciate your testimony.

I believe now that does conclude our testimony on Senate Bill 46. So we will proceed to House Bill 6277, and we've got Steve Karp first.

STEPHEN KARP: Good afternoon, I'm Stephen Karp, executive director for National Association of Social Workers Connecticut Chapter, and we thank the committee for raising this bill.

We are a nonprofit association. We're also a small business with six employees. It's our

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**Testimony of Gretchen Vivier, MSW**
**Before the Insurance and Real Estate Committee**
**February 5, 2009**

Good afternoon Senator Crisco, Representative Fontana, and Committee Members. My name is Gretchen Vivier. I am the Health Care Organizer at the Connecticut Chapter of the National Association of Social Workers (NASW).

NASW supports Proposed S. B. No. 46 AN ACT CONCERNING TRANSPARENCY OF MEDICAL LOSS RATIO INFORMATION.

With all of the people suffering due to the lack of quality affordable health care, we need to do all we can to spend our health care dollars as wisely as possible. Transparency of the numbers that go into the medical loss ratio will give us some of the information we need in order to do that. Then we will know just how much is spent in processing claims and managing chronic disease as opposed to marketing and executive salaries. Then a judgment can be made as to whether we really believe that is the best way to spend our health care dollars.

Some may say that we really need to focus on the 80-90% that is actually spent on health care. Whether or not it is spent in the most efficient manner is obviously important. However, at least that money is going to health care. We also need to control the money that is not getting anyone any health care.

To put this into perspective, let's look at the salary of one insurance company executive in this state. The $25,000,000 he made in one year, could have insured 2000 families in Connecticut or put over 100 doctors through medical school.

We urge you to pass this bill out of committee.

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Anthem.

February 5, 2009

**Statement**
**Of**
**Anthem Blue Cross and Blue Shield**
**On**

**SB 46 An Act Concerning Transparency of Medical Loss Ratio Information**

Good afternoon Senator Crisco, Representative Fontana and members of the Insurance Committee, my name is Christine Cappiello and I am the Director of Government Relations for Anthem Blue Cross and Blue Shield in Connecticut. I am on here to speak on **SB 46 An Act Concerning Transparency of Medical Loss Ratio Information.**

We are against this bill because we believe that consumers having this information will only serve to confuse them rather than help them and this bill will create an anti-competitive nature among insurance carriers. Medical Loss Ratio (MLR) is a metric that bears little relationship to the quality of a health insurance product should and not be used by consumers as an indicator of value. In the words of U.C. Berkeley professor and *Health Affairs* editor James Robinson, "the medical loss ratio is an accounting monstrosity that enthralls the unsophisticated observer and distorts the policy discourse."

As mentioned previously we believe this bill has 2 major problems. **(1) An MLR reported by product will be extremely confusing to consumers.** While an MLR should not be used in the first place as an indicator of the value of a health insurance product, it is especially misleading on a product-by-product basis. This is because small pools are less stable than large pools and insurers will often pool risk between and cross-subsidize the medical risk. Thus, in any given year, one product may experience a high MLR while another product experiences a low MLR. Such variances will be much more confusing than valuable to consumers. **(2) The release of proprietary information will have a negative, anti-competitive impact.** Connecticut has a very robust health insurance marketplace, with each competitor seeking to differentiate themselves in innovative ways that make them more attractive to customers. Such a competitive marketplace is good for consumers and healthy for the state. The MLR by product is possibly considered to be the most proprietary metric from a competitive perspective, and thus releasing this data will have a significant anticompetitive impact. Such a requirement is akin to requiring an automobile company to report how much it costs to manufacture each type of vehicle in its fleet. The result is that there will be a reduced incentive to be successful, and private companies will seek to mimic their competitors' high-profit successes instead of working to differentiate themselves in innovative ways.

There are many misconceptions regarding exactly what costs fall under the category of administrative expenses. It is important to understand that health insurance plan's administrative expenses, under most definitions reflect costs for claims processing; disease management and care coordination; information technology and patient services; establishment of provider networks; product development and sales; consumer education and outreach; as well as taxes, fees, and profit.

We ask that the committee respectfully not move forward with this legislation and I am available to answer any questions you might have.

CITIZENS FOR ECONOMIC OPPORTUNITY
*Corporate Responsibility Campaign*

**S.B. 46 – An Act Concerning Transparency of Medical Loss Ratio Information**

My name is Karen Schuessler and I am the Director of Citizens for Economic Opportunity (CEO). CEO is a coalition of community and labor groups addressing health care reform and corporate responsibility.

I strongly support S.B. 46. Establishing greater transparency regarding the medical loss ratio is a giant step in making the health care system more efficient and ensuring that all Connecticut residents have health care that is affordable and accessible.

As you know, a medical loss ratio is a requirement that insurers spend, at least, a specified percentage of premium dollars on medical care as opposed to administration, marketing and profit. Transparency of the medical loss ratio is important for many reasons including the following:

1. The United States spends $350 billion a year on health care administration and paperwork.
2. Healthcare premiums in Connecticut rose 8.2 times faster than median earnings from 2000 to 2007.
3. CEO pay for insurance companies is excessive and extravagant. Ronald Williams, the CEO of Aetna made $23,045,834 in total compensation in 2007.
4. Some insurance companies value profits at the expense of policyholders. For too many insurance companies, the name of the game is deny, delay and defend to avoid paying claims. Last year, here in Connecticut, Assurant Health denied hundreds of claims alleging that patients had health problems that pre-dated their policies. The Connecticut Insurance Department had an outside firm re-examine 811 claims. A settlement was reached and Assurant companies paid more than $255,000 in restitution and interest on 39 previously denied health insurance claims.

Establishing transparency is the right step in ensuring that our health care dollar is being spent to make people well and not on profit and administration. However, it is only the beginning and I urge you to go a step further and support a medical loss ratio of no less than 87.5%. If an insurer fails to spend enough on medical care to meet the minimum medical loss ratio, it must either refund consumers or adjust their premiums. Families USA conducted interviews with insurance regulators in 19 states and learned that insurers in the individual market sometimes maintain medical ratios of only 60% and retain 40% of premium dollars for administration, marketing and profit.

A number of states are implementing medical loss ratios to reduce excessive profits. New Jersey requires individual and small group insurers to spend 75% of the premium dollars on medical care. Insurers set the premiums at the beginning of the year and file a certification that medical claims will

exceed 75% of premiums. Insurers must report annually and at the end of the year if the amount spent on medical claims is less than 75% of collected premiums, they issue refunds which has resulted in $11.6 million dollars being refunded to consumers between 1993 and 2006.

Other states have refunded money to policy holders. As a result of Maine's medical loss ratio, one Maine insurance company refunded policyholders $6.6 million and another one refunded policy holders $1 million. In May 2008, it was announced by the New York Governor and the Department of Insurance that Oxford Health Insurance will refund $50 million to 37,000 small businesses in the state because in 2006, they did not achieve the 75% minimum medical loss ratio.

I appreciate your efforts to make health care more efficient and urge your support of this bill. I also hope you will adopt a medical loss ratio of no less than 87.5% which would result in money being refunded to policyholders and may increase doctors ' reimbursements.

Karen Schuessler
Director
Citizens for Economic Opportunity
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Testimony of Richard Sivel, Health Care Organizer
Council 4 AFSCME
Before the Insurance and Real Estate Committee, Connecticut General Assembly
In Support of Senate Bill 46
"An Act Concerning Transparency of Medical Loss Ratio Information"
February 5, 2009

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I am here to testify in support of Senate Bill 46 for Council 4 AFSCME, representing more than 37,000 workers in the public service. We strongly support the bill's intent to require health insurers to report to consumers - before they sign on the dotted line - the percentage spent on patients and medical care versus administration and profits.

We also should go farther in this bill to give consumers information to effectively compare plans and get maximum value for their health dollar. This starts with ensuring the legislation includes a better *definition* of "medical loss ratio". We should limit the insurance industry's ability to mask their costs and game the system by requiring them to accurately report all of their non-medical costs Some steps we can take are·

- Insurance subcontractor administration costs should be reported as administration, not care.
- Investment and other income should be used to calculate loss ratio, not just premiums, and
- Loss ratios should be provided for each line of business and health benefit plan, not aggregated across all product lines[1]

This legislation should also go farther to protect consumers, including but not limited to[2]

- Establishing a minimum medical loss ratio using public insurance as a reference
- Requiring insurers to provide refunds to consumers if they exceed a minimum threshold[3]
- Providing much more transparency for consumers and establishing better rules on how the private insurance industry makes coverage decisions, provides services, sets payment rates and provider incentive structures, and
- Making available (non-patient specific) claims and outcomes data.

Setting rules and shedding light on the private insurance industry is important, but we must work hard to provide Connecticut residents with a guaranteed, secure, public health insurance alternative like Traditional Medicare – or, as we've been working on just for Connecticut, open up the State Employee Health Plan – to keep the private insurance companies in check.

All of this information and more should be the public's business. AFSCME has a unique understanding due to our work on state and national health care reform, our seat on the cost containment committee of the State Employee Health Plan (which has medical loss ratios in

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[1] Proposed by Governor Schwarzenegger in California in 2007
[2] Resources· See Families' USA report at http //www familiesusa org/assets/pdfs/medical-loss-ratio pdf and Progressive States Network at http //www progressivestates.org/policy/issue/114
[3] States such as Maine, New Jersey and New York do this

excess of 90 percent and had a zero percent cost increase last year), and our work to preserve the benefits of municipal health insurance plans.

The amount of money spent on care versus profits is no secret in public insurance plans which are free from private insurer middlemen. This includes many plans in Connecticut, such as self-insured municipal plans and Medicare. Medicare administration costs are 3 to 5 percent versus an average 30 percent or higher for private industry. If publicly-regulated health plans can function openly, so can and should the private plans.

Connecticut legislators and Congress are readying to guarantee affordable, quality health care for all residents in this state and across America The insurance industry is gearing up to oppose this effort and fight what is right at every turn. SB 46 will help people now and show them the better choices they can have under health care reform – including a choice of a public health insurance plan. The insurers should be required to compete with the public insurance plans on a level playing field, and prove to us that their real motto isn't "All Premiums, No Care "

Private plans will continue to wrongly deny claims, penalize pre-existing conditions, avoid risk and shift costs with little accountability unless we disincentivize this behavior. Bill such as SB 46 won't fix the industry, but will provide important information as a meaningful step in this process. Thank you

*Quality is Our Bottom Line*

**Insurance Committee Public Hearing**
**Thursday, February 5, 2009**

**Connecticut Association of Health Plans**
**Testimony regarding**

**SB 46 AAC Transparency of Medical Loss Ratio Information.**

The Connecticut Association of Health Plans is pleased to offer testimony regarding SB 46 AAC Transparency of Medical Loss Information.

As you know, health plans are already required to report their medical loss ratio to the Department of Insurance and we support the concept of transparency in this regard.

Administrative costs are an important component of the health care delivery system and ought to be viewed as such. Disease management of chronic conditions like diabetes and/or asthma fall into the category of administrative costs, as do technology improvements that enhance the infrastructure of a health plan's administration.

Both examples, ultimately improve the delivery of health care to consumers and to providers. However, investments in these areas may require health plans to front-end the expenditures so that the results can be seen in the out-years. It is important that medical loss ratios be understood in this context. Health plans need financial flexibility in terms of developing benefit and product designs that meet the individual needs of their customers as well as the flexibility to invest in efficiencies that are aimed toward the greater good. Depending on the size of a group insured, administrative costs may vary. The larger the group, the more dispersed administrative costs may be. We hope that as the Committee continues its deliberations on bills such as SB 46 that appropriate consideration will be given to these aspects of the debate.

Many thanks.

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**Testimony of the Connecticut Society of Eye Physicians**
**CT ENT Society**
**CT Dermatology and Dermatologic Surgery Society**
**On**
**SB 46, An Act Concerning Transparency of Medical Loss Ratio Information**
**Presented to the Insurance and Real Estate Committee**
**By**
**Steven Thornquist, M.D.**

SB457

**February 5, 2009**

Good morning Senator Crisco, Representative Fontana, and distinguished members of the Insurance Committee. My name is Steven Thornquist, M.D. I am the Secretary of the Connecticut State Medical Society and Past President of the CT Society of Eye Physicians and I am here representing over 700 physicians practicing ophthalmology, dermatology and ENT medicine in Connecticut. I am here today to support SB46, a bill that would provide real and useful information on the efficiencies of the organizations looking to contract and manage healthcare premium dollars for consumers and business in Connecticut. This legislation would provide this information in the form of a standard ratio of premium dollars and direct medical expenses at the point of purchase and allow direct comparison.

People and businesses in the United States are facing economic challenges that are unprecedented in our lifetime, and it has become increasingly important for patients to become informed consumers and partners in their own health care. Currently, there are physician profiles available which allows patients to research their providers, and with the growing popularity of the World Wide Web, it is easier than ever for them to select a highly skilled and expertly qualified

physician. Patients routinely use the web to learn more about their health problems and the treatment options, prognosis, and other resources available today. Consumer health care education, however, comes to an abrupt halt when it comes to insurance companies and Managed care organizations.

We spend a great deal of time selecting our providers, who may or may not be "in-network", but we have only limited access to information that would enable us to make informed decisions about the insurers we "hire" to manage our healthcare dollars in an efficient manner. This includes the details about insurers that actually provide coverage for the various treatment options available and their efficiency in managing premium dollars. Too often, we as consumers review only the cost of the premium and the provider networks to see if our "doc" is there, when making a choice on which insurer is better. Consumers need more information to make informed decisions on the overall performance of the carrier. They need to know how much of their healthcare premium is being spent on direct healthcare costs. Doesn't it make sense for consumers to purchase a policy which is reasonably priced and uses more of their premium dollars on benefits versus administrative costs- including run-away bonus compensation packages for CEOs and marketing expenses?

SB 46 is a good start to providing this much needed transparency. Another bill dealing with transparency SB457 had a public hearing last week. This bill is another piece to the Transparency picture- it required that the Insurance Department post the medical loss ratios on the

Consumer Report Card. By passing both of these bills we will begin to educate the consumer and identify the (administrative?) medical expenses in the healthcare premium equation and look to build more efficiencies in an industry that has gone far too long unchecked. Transparency is the best way to insure competition and better performance and to establish the checks and balances needed to ensure cost control and accountability.

We as Americans cannot afford another industry bailout, nor can we afford the ever rising healthcare premiums which, in the eyes of healthcare providers, seem disconnected from direct healthcare costs. Healthcare providers across the state hope you will take this important step towards Transparency and shed some light on the high price of healthcare premiums and ultimately make us all better consumers with this knowledge.

Please support both SB 47 and SB457 and help bring Connecticut out of the darkness. Thank you

Connecticut State Medical Society
FOUNDED IN 1792

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**Connecticut State Medical Society Testimony on**
**Senate Bill 46 An Act Concerning Transparency of Medical Loss Ratio Information**
**Presented to the Insurance And Real Estate Committee**
**February 5, 2009**

Senator Crisco, Representative Fontana and members of the Insurance and Real Estate Committee, my name is Ken Ferrucci, Vice President of Public Policy and Government Affairs for the Connecticut State Medical Society (CSMS). On behalf of our over 7,000 members, thank you for the opportunity to submit this testimony to you today on **Senate Bill 46 An Act Concerning Transparency of Medical Loss Ratio Information.**

CSMS supports **Senate Bill 46 An Act Concerning Transparency of Medical Loss Ratio Information** which would require health insurers in this state to disclose the medical loss ratio of the company or organization at the time of contracting. CSMS has consistently advocated for transparency in all aspects of the health insurance industry and strongly believes that consumers have a right to know the exact portion of premium dollars that are spent directly on health care services. Similar laws have currently been passed in fifteen states and have yielded improved transparency of insurer practices- a clear "win" for both patients and physicians.

Insurance companies are not currently required to provide consumers or employers with highly detailed information about how their premium dollars are spent. At a time when consumer premiums are increasing and physician reimbursements are dropping or stagnant, health insurance company profits continue to rise. True transparency is essential to eliminated unnecessary costs within the system. If consumers and employers are to make educated health care decisions, they need accurate and detailed data on how insurers spend their premium dollars.

To further ensure that detailed information is available we respectfully ask that the definition of "loss ratio" that currently exists in state statute be more clearly defined to delineate such expenditures. As defined "loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations. We suggest changing the definition to mean the total number of medical expenses divided by total premiums and subsequently define "medical expenses," "Premiums", "and "administrative costs." Respectively the terms would be as follows:

Medical expenses- the total amount of money that the insurer spends on direct medical care services for enrollees. This includes the total financial obligation for physician services, non-physician healthcare professional services, hospital and other health facility services, drugs and medical devices, and other health care services that the health insurer incurs on behalf of its enrollees.

Premiums- the amount that the purchaser pays to the health insurer to purchase health care coverage

Administrative Costs- include but aren't limited to, costs associated with claims processing, collection of premiums, marketing, operations, taxes, general overhead, salaries and benefits, quality assurance, utilization review and management, pharmacy and other benefit management, network contracting and management, and state and federal regulatory compliance.

Thank you for the opportunity to share these comments with you. We welcome any questions or comments.

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Testimony of Phil Sherwood
Deputy Director of the Connecticut Citizen Action Group
Before the Insurance and Real Estate Committee
February 5th, 2009

Good afternoon Senator Crisco, Representative Fontana and other members of the Insurance and Real Estate Committee. My name is Phil Sherwood and I am the Deputy Director of the Connecticut Citizen Action Group (CCAG). CCAG has approximately 25,000 members and is currently the state's oldest and largest public interest group.

**CCAG would like to express strong organizational support for SB 46, AAC Transparency of Medical Loss Ratio Information.**

CCAG supports the efforts behind this legislation that aim to increase and provide transparency for consumers by requiring the disclosure of the medical loss ratio of that company or organization. We believe that, in an effort to increase competition and efficiency in the health care system, there be a minimum medical loss ratio established. Setting these standards also guards against wasteful administrative costs and excessive profits, and protects consumers.

Specifically with insurers, it is important that the state set benchmarks that require insurers spend at least, 87.5% of our premium dollars on medical care. Now more than ever, it's vital that the public and policy makers are provided the information that demonstrates how much an insurer is spending on administration, marketing and profit. Setting a minimum medical loss ratio encourages efficiencies and competition; two things sorely needed if we are to control the cost of health care premiums.

Other states require insurers to meet minimum medical loss ratios in the small group, individual, Medicare supplement, long term care markets and HMO's in order to increase the portion of premium dollars that are dedicated to actual medical services.

When an insurer exceeds that minimum medical loss ratio they should be required, at a minimum, to refund policy holders and be subjected to fines from the state. Perhaps more importantly, data has shown that states that have implemented a minimum medical loss ratio have been more successful at controlling premiums.

Ultimately, we may not all come to the same conclusion as to what system would work best to provide quality affordable health care for all, but most can agree that the current system is broken, inefficient and lacks sufficient transparency and accountability.

I would like to thank this committee for taking the time to hear our concerns and thoughts on SB 46 and for considering ways to increase the transparency and efficiency of our health care system.

## Medical Loss Ratio Requirements

| | Individual Market | Small Group Market | Other | Statutory Reference |
|---|---|---|---|---|
| California | | | Managed care plans: Administrative costs not to be excessive; limited to 15% to 25% based on developmental phase of plan. Administrative costs do not include some items such as salaries, stock options, etc. | California Health And Safety Code HSC Section 1375, enforced through Cal. Admin. Code tit. 28, § 1300.78 |
| Delaware[a] | | 75% | | Title 18 Chapter 71 § 7106 |
| Kentucky | 65% | Groups of 2-10: 70%<br>Groups of 11-50: 75% | | KRS 304.17A.095[b] |
| Maine | 65% | Insurers that file rates every two years: 75%<br>Insurers that file rates every three years: 78% | | Title 24-A, Chapter 33, §2736-C[c]<br>§2808-B[d] |
| Maryland | 60% | 75% | | Maryland Code § 15-605[e] |
| Minnesota | 65% | Groups of 2-10: 72%<br>Groups of 11-50: 73% | Large group coverage: 85% | 62A.021[f] |
| Nevada | | | Nonprofit corporations: 75%<br>Individual dental insurance: 75% | NRS 695B.170<br>NRS 686B.125 |
| New Jersey | 75% | 75% | | 78:27A-25 |
| New York | 82% | 75% | | § 3231(j)(7)(A) |
| North Dakota | 65% | 70% | | 26.1-36.2-12 |
| Oklahoma | | 60% | | 36 O.S. 6515 |
| South Dakota | 65% | 75% | | Ind. § 27-8-5-3<br>58-18-53[g] |
| Vermont | 70% | | Subsidized market: 80% | Title 8 Chapter 107 4080b[h] Chart |
| Washington | 77% | 77% | | 48.52[i] |
| Wyoming | 60% | 72% | | Individual: Chapter 33 Article 6C § 33-6C-[j]<br>Small Group: §33-18D-5[k] |

## Table Notes

[a] Delaware's statute says that it follows the standards of the National Association of Insurance Commissioners (NAIC) to determine medical loss ratios in the individual market (http://delcode.delaware.gov/title18/c025/index.shtml).

[b] http://www.lrc.ky.gov/krs/304-17A/095.PDF

[c] http://janus.state.me.us/legis/statutes/24-A/title24-Asec2736-C.html

[d] http://janus.state.me.us/legis/statutes/24-A/title24-Asec2808-B.html

[e] http://www.michie.com/maryland/lpext.dll/mdcode/162b2/1736e/17557/1756c

[f] https://www.revisor.leg.state.mn.us/bin/getpub.php?type=s&num=62A.021&year=2007

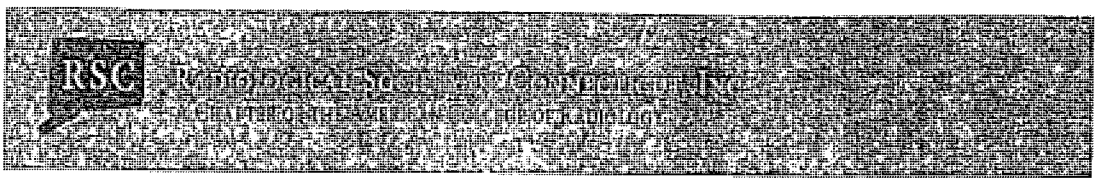
[g] http://legis.state.sd.us/statutes/DisplayStatute.aspx?Type=Statute&Statute=58-17-64

[h] http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=08&Chapter=107&Section=04080b

[i] http://apps.leg.wa.gov/documents/billdocs/2007-08/Pdf/Bills/Session%20Law%202008/5261-S.SL.pdf

[j] http://www.legis.state.wv.us/wvcode/code.cfm?chap=33&art=6C#06C

[k] http://www.legis.state.wv.us/wvcode/code.cfm?chap=33&art=16D&section=WVC%2033%20%20-%2016%20D-%20%20%201%20%20.htm#01



Statement of the
Radiological Society of Connecticut
before the
Insurance and Real Estate Committee
in support of SB 46 and SB 47
February 5, 2009

46
47

Sen. Crisco, Rep. Fontana and members of the committee:

My name is Linda Kowalski. I am executive director of the Radiological Society of Connecticut, which is comprised of Medical Doctors who engage in the practice of radiology. The Society would like to offer comments on two bills before you today.

**Senate Bill 46, AAC Transparency in Medical Loss Ratio Information**

RSC believes this legislation will provide valuable information to consumers about the financial status of health insurers and managed care plans. Specifically, it will require that reports list the amount of medical claims that have been paid by the policy issuer compared to the revenue received from premiums and other income. This "medical loss ratio" will be a valuable piece of information for consumers to have in deciding whether or not they want to do business with a given company.

**Senate Bill 47, AAC Health Care Provider Contracts**

RSC also strongly supports SB 47. This legislation will "level the playing field" when it comes to medical provider relationships with managed care organizations and insurers. It would prohibit such organizations from unilaterally changing terms of an agreement in areas such as fee schedules, provider panels and negotiating rights. These are very reasonable limits on unilateral action and we would urge the committee to approve them. Importantly, it would establish a 90 day "lookback" period on recouping payments for services that were duly authorized, delivered and paid for.

In conclusion, Connecticut's radiologists are dedicated professionals who play a major role in ensuring that patients benefit from state-of-the-art radiological and imaging services. They are asking that you create a higher degree of fairness to the administrative process that exists with their payors. Both SB 46 and SB 47 do this.

Thank you for considering our position on this legislation. We look forward to working with you on these important issues during the 2009 session.

SENATOR MARTIN M. LOONEY
MAJORITY LEADER

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299, 47, 46

February 5, 2009

SB 457

Good Morning Senator Crisco, Representative Fontana and members of the Insurance and Real Estate Committee. I am here to testify in support of three bills that are on the agenda this afternoon: S. B. No. 299 AN ACT EXPANDING HEALTH INSURANCE COVERAGE FOR ROUTINE PATIENT CARE COSTS FOR CLINICAL TRIAL PATIENTS, S. B. No. 47 AN ACT CONCERNING HEALTH CARE PROVIDER CONTRACTS, and S. B. No. 46 AN ACT CONCERNING TRANSPARENCY OF MEDICAL LOSS RATIO INFORMATION

SB 299, AN ACT EXPANDING HEALTH INSURANCE COVERAGE FOR ROUTINE PATIENT CARE COSTS FOR CLINICAL TRIAL PATIENTS, would expand coverage of routine patient care costs for clinical trial patients to clinical trials for serious or life threatening diseases and ensure that third party payers retain their responsibility to patients. In 2001 the Connecticut General Assembly passed PA 01-171 which required insurers to sustain their responsibility to

Under President Clinton, Medicare made this common sense change to cover routine patient care costs for clinical trial patients. I believe that the Connecticut General Assembly should make this same change.

I would also like to express my support for SB No. 47 AN ACT CONCERNING HEALTH CARE PROVIDER CONTRACTS. This bill would address the need to prohibit insurance companies from making unilateral changes to contracts and the need to require insurance companies to disclose the full Current Procedural Technology (CPT) fee schedule disclosure. These represent important and necessary changes to our insurance statutes.

Last week I testified in support of and suggest some modifications to S.B. 457, AN ACT CONCERNING CONSUMER REPORT CARDS. I would like to offer similar comments in regard to SB 46, An Act Concerning Transparency of Medical Loss Ratio Information.

Transparency is always the best tool for educated decision-making. Currently the MCOs must report medical loss ratio to the Insurance Department; the Department should include this information on its Consumer Report Card as would be required under SB 457. I believe that MCOs should also be required to report their Medical Loss Ratios to any employer or individual who is attempting

to choose a health insurance plan which is required by SB 46. This data would allow potential customers to choose a plan that emphasized medical coverage rather than administration. It is difficult to conceive of an argument against this policy; surely no one could sincerely claim that Medical Loss Ratio is proprietary information. The MCOs are not being asked to provide detailed data or information on the inner workings of the corporation. Allowing a consumer to compare plans' spending priorities is simply common sense.

I would also suggest that CGS section 38a-478l(b) be amended to require MCOs to release the Current Procedural Technology (CPT) code, National Uniform Billing Committee (NUBC) code, National Drug Code (NDC), and Healthcare Common Procedure Coding System HCPCS payments to the Commissioner of Insurance for use in the consumer report card. This disclosure of the dollars actually paid to providers would be an additional tool to help consumers make a more educated choice regarding health insurance. I believe that these proposals would increase transparency in the market and thus create a more rational healthcare system.

Thank you.

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HB5093 SB299 SB638
SB46 HB6277 HB5172
SB47

**Testimony of Kevin Lembo, State Healthcare Advocate**
**Before the Insurance and Real Estate Committee**
**In Support of S.B. 301**
**February 5, 2009**

Good morning Senator Crisco, Representative Fontana, Senator Caligiuri, Representative D'Amelio and members of the Insurance and Real Estate Committee. For the record, I am Kevin Lembo, the State Healthcare Advocate. My office is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

I am here today to testify in favor of S.B. 301, AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDERS, the purpose of which is to provide comprehensive health insurance coverage for autism spectrum disorders. Last year, I testified in support of a bill promoted by Senator Crisco and Representative Abercrombie that required insurers to cover therapy services for children on the autism spectrum on par with therapy services provided to those with physical illnesses. That bill was a first step toward ensuring parity in treatment for people with an autism spectrum disorder. S.B. 301 will move the ball further down the field by acknowledging that Applied Behavioral Analysis (ABA), is not an experimental treatment, and must be covered if medically necessary.

Connecticut's mental health parity law requires coverage for the diagnosis and treatment of mental health disorders listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) on par with medical surgical or other physical conditions. Autism spectrum disorders (ASD) are listed in the most recent edition of the DSM, and therefore, coverage for ASD should be on par other illnesses. Like many other mental disorders, the treatment for ASD involves more than psychological treatment. In most circumstances treatment also involves prescription medications and physical, speech and occupational therapies. It is not unlike many medical illnesses, which also require more than one modality of treatment.

While ABA has gained scientific acceptance and is recognized as a psychological treatment for ASD by the American Academy of Pediatrics, the insurers in our state still do not recognize ABA's validity and continue to deny legitimate mental health treatment to those with ASD. Our office has represented several of these consumers in front of managed care organization panels. While we were able to get coverage for ABA on a

case-by-case basis as an exception, there should be no need to have to climb over so many hurdles to get medically necessary treatment.

Physical therapy, speech therapy and occupational therapy are often provided in concert with other treatments for ASD. Last year's legislation was a step toward ensuring that adequate therapeutic treatment is available for those with ASD. This year's legislation, to provide comprehensive health insurance coverage for ASD, would go further. It is consistent with the principle that insurers should be required to cover medically necessary care, whether it means two speech therapy sessions or forty. There should be no distinction between coverage for ongoing and medically necessary physical therapy, speech therapy and occupational therapy for ASD patients and ongoing medication regimes for chronic mental illness. Both treatment regimes derive from recognized mental disorders and should be treated equivalently.

Ongoing treatment, like that for all mental disorders, may be subject to utilization review initially and at appropriate intervals for the appropriate management of care.

Lastly, it is important to note that the passage of the proposed bill would not require the substitution of insurance coverage for required and appropriate educational planning. The bill would augment the limitations of individual educational plans by balancing the obligations of school systems with the reality that ASD is a 24-hour per day mental condition. We expect to access medically necessary treatment for such chronic conditions and when we purchase health insurance, we expect our insurer to pay for that treatment. SB 301 will explicitly reinforce the insurer's obligation.

Other Bills We Support

HB 5093, SB 299, SB 638 would require prosthetic parity, expand coverage for routine costs in cancer clinical trials, and require coverage for more recent colon cancer screening for colon cancer survivors. Each of these bills is consistent with my office's statement that medically necessary healthcare should be covered regardless of diagnosis or service. Continuing to amend our statutes by individual diseases or treatments gives us less and less margin to ensure we cover all medically necessary care. Each of these issues should be considered as part of a larger healthcare discussion.

OHA also supports SB 46, AN ACT CONCERNING TRANSPARENCY OF MEDICAL LOSS RATIO INFORMATION. I have consistently testified that transparency on the medical loss ratio and other managed care organization information not only assists consumers in purchasing their insurance, but also informs policymakers and group purchasers of at least one measurement of an organization's operations. We don't believe this requirement is burdensome. The managed care organizations are required to include this information in their summary plan descriptions. Revealing them at the time of purchase without a separate request for the information means the addition of one additional piece information to their sales materials.

We support HB 6277, AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR SMALL EMPLOYERS, which would reduce from thirty to twenty

# JOINT
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**2009**

Connecticut State Medical Society
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**Connecticut State Medical Society Testimony**
**House Bill 6530 An Act Concerning the Accessibility and Effectiveness of Consumer Report Cards and Transparency In Health Insurance Claims Date**
**Senate Bill 961 An Act Concerning Medical Malpractice Data Reporting**
**Senate Bill 962 An Act Concerning Wellness Incentives**
**Insurance and Real Estate Committee.**
**February 24, 2009**

Senator Crisco, Representative Fontana and members of the Insurance And Real Estate Committee, on behalf of the more than 7,000 members of the Connecticut State Medical Society (CSMS) thank you for the opportunity to present this testimony to you today on **House Bill 6530 An Act Concerning the Accessibility and Effectiveness of Consumer Report Cards and Transparency in Health Insurance Data Claims**. This bill attempts to strengthen initiatives to provide consumers with reports about health centers, health insurers and the provider networks contracted with them. CSMS has regularly promoted and support these efforts in our State. This will provide greater access to information relevant and necessary for consumers, employers and physicians to make educated decisions regarding the purchasing of health insurance and provision of healthcare.

In general, the Bill will allow both employers and consumers to have better information about certain aspects of their respective relationships with their insurers. Relevant cost and reimbursement insurer information will be made available. While we welcome the opportunity to work with committees to strengthen appropriate reporting requirements, the language before you today appears confusing and without proper context or understanding of underlying circumstances may prove misleading to employers and consumers. For example, member utilization rates among doctors may seem very much askew, unless one is able to contextualize the relationship of the doctor to the member population.

Recently, CSMS has testified before you on similar bills to expand the consumer report card to include the medical loss ratio of medical liability insurers (Senate Bill 457 An Act Concerning Consumer Report Cards) and to strengthen the definition of medical loss ratio on (Senate Bill 46 An Act Concerning Transparency of Medical Loss Ratio Information). We suggest to the committee today that accepting our testimony on those bills that included the attached definitions related to medical loss ratios as developed by the AMA would allow this committee to accomplish the goal of HB 6530 in a more clear and concise manner.

CSMS has consistently supported the collection ad reporting of Medical Liability Closed Claims Data. CSMS supports the expansion of the current statute as would be required in **Senate Bill 961 An Act Concerning Medical Malpractice Data Reporting.** The legislation before you will capture a fast growing