Act Number:	09-049	
Bill Number:	959	
Senate Pages:	1108-1111, 1128-1131	**8**
House Pages:	3108-3112	**5**
Committee:	Insurance: 1814-1815, 1830-1834, 1857-1859, 1874, 1875, 1881-1887	**19**
	Page Total:	**32**

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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:

Thank you, Mr. President. 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, will you like to remark further?

SENATOR CRISCO:

Yes, Mr. President. The Clerk has an amendment, LCO 5387. I ask that it be called and I be give permission to summarize.

THE CHAIR:

Mr. Clerk.

THE CLERK:

LCO 5837, which will be designated Senate Amendment Schedule A. It is offered by Senator Crisco of the 17th district.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. Mr. President, in summary, this amendment --

THE CHAIR:

Senator Crisco, do you move adoption, sir?

SENATOR CRISCO:

Yes, I'm sorry. I move adoption of the amendment, Mr. President.

THE CHAIR:

Please proceed, sir.

SENATOR CRISCO:

Mr. President, this amendment defines what we mean by review entity for clarification, and other technical minutes.

THE CHAIR:

Thank you, sir. Will you remark further on Senate Amendment A? Will you remark further? If not, I will try your minds. All those in favor, signify by saying, aye.

SENATORS:

Aye.

THE CHAIR:

Opposed, nays.

The ayes have it. Senate Amendment A is adopted. Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President. Mr. President, in summary, the bill establishes an expedited external appeal process for health care plan enrollee of his or her health care provider to use after his or her

health insurer, or similar entity denies coverage for procedure or a treatment that has not yet been received and the time frame for completing the entity's expedited internal appeal could cause or worsen a life-threatening or emergency situation.

Basically, the bill adopts standards, criteria, qualifications for clinical reviewers and provides an excellent process for appealing a decision.

THE CHAIR:

Thank you, sir. Will you remark? Will you remark further on Senate Bill 959 as amended? Do you remark? Senator Crisco.

SENATOR CRISCO:

Mr. President, if there's no objection, I ask that it be placed on the consent calendar.

THE CHAIR:

Motion is on consent. Seeing no objection, so ordered. Mr. Clerk.

THE CLERK:

Calendar Number 262, file number 288, substitute for Senate Bill 960, AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS' RECOMMENDATIONS FOR TECHNICAL REVISIONS TO THE INSURANCE STATUTES, favorable report of the committee on insurance.

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

THE CLERK:

House Bill 6328 as amended by House A.

Total Number Voting	143
Necessary for Passage	72
Those voting Yea	122
Those voting Nay	21
Those absent and not voting	8

SPEAKER DONOVAN:

The bill as amended is passed.

Will the Clerk please call Calendar Number 441.

THE CLERK:

On page 16, Calendar 441, substitute for Senate Bill Number 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 and Real Estate.

SPEAKER DONOVAN:

Representative Steve 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 in concurrence with the Senate. Will you remark, sir?

REP. FONTANA (87th):

Thank you, Mr. Speaker. Mr. Speaker, this bill establishes an expedited, external appeal process for a health plan enrollee to use when his or her health insurer denies coverage for a procedure or treatment that he or she has not yet received in a timeframe for completing the insurer's expedited internal appeal process -- could cause or worsen a life-threatening or emergency situation. This bill adopts one, standards criteria and record maintenance and reporting requirements for review entities; and two, qualifications for clinical reviewers. The bill also makes a review entity's decision regarding a standard or expedited external review binding on both an enrollee and an insurer.

Finally, the bill specifies that it does not limit or prohibit any other remedy available under

federal or state law. Mr. Speaker, the Clerk has an amendment, LCO 5837. I ask that he call it and that I receive permission to summarize.

SPEAKER DONOVAN:

Will the Clerk please call LCO 5387, designated Senate A.

THE CLERK:

LCO Number 5387, Senate Amendment Schedule A, offered by Senator Crisco and Representative Fontana.

SPEAKER DONOVAN:

Representative seeks leave of the chamber to summarize. Is there objection with summarization? If not, Representative Fontana, you may proceed with summarization.

REP. FONTANA (87th):

Thank you, Mr. Speaker. Mr. Speaker, this amendment moves the definition of the term "review entity" and makes other technical changes. I move for its adoption.

SPEAKER DONOVAN:

The question before the chamber is adoption of Senate Amendment Schedule A. 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? Representative D'Amelio.

REP. D'AMELIO (71st):

Thank you, Mr. Speaker. Mr. Speaker, I rise in support of this bill. As my colleague on the insurance committee mentioned, it does establish a fair and uniform process for handling these external appeals and consumers are provided with greater rights and assurances in this bill. So I urge the chamber's adoption. Thank you, Mr. Speaker.

SPEAKER DONOVAN:

Thank you, Representative.

Will you remark on the bill as amended? Will you remark on the bill as amended? If not, staff and guests, come to the well 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? If all the members voted, please check the board to make sure your vote has been properly cast. If all the members have voted, the machine will be locked and the Clerk will please take a tally. Clerk, please announce the tally.

THE CLERK:

Senate Bill that 959 as amended by Senate A, 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:

The bill passes in concurrence with the Senate.

Will the Clerk please call Calendar Number 127.

THE CLERK:

On page 32, Calendar 127, substitute for House Bill Number 5519, AN ACT CONCERNING WORKERS' COMPENSATION PREMIUMS AND VOLUNTEER AMBULANCE

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underneath, actually, on the side --

MATTHEW KATZ: All it does it drop it down farther. It doesn't help me.

REP. FONTANA: Oh, sorry.

MATTHEW KATZ: Senator Crisco, Representative Fontana and members of the Insurance and Real Estate Committee, my name is Matthew Katz, and I'm the executive vice president of the Connecticut State Medical Society.

On behalf of our more than 7,000 members, thank you for the opportunity to present this testimony to you in support of Senate Bill 959, an Act Concerning External Appeals of Adverse Determinations by a Managed Care Organization, Health Insurer or Utilization Review Company. Say that five times really fast.
This bill really provides -- and you have my written testimony. It provides consumers, the patients, with improved transparency associated with the performance and oversight of those organizations that often review the services provided to them by physicians.

CSMS believes that this bill provides physicians with the necessary tools to advocate for their patients' medically necessary care when a health insurer or other entity may initially deny such medical care. A physician's determination what is and is not medically necessary is paramount to ensuring quality patient medical care.

This bill creates a new definition for "adverse determination," which the medical society strongly supports. This bill also provides specific and stringent guidelines

associated with what utilization review committees can and can't do and how timely -- and it is key from the perspective of timeliness of these reviews -- how timely they have to respond to issues, get information to physicians and patients, as well as allowing the -- in this case, the enrollee or the provider acting on behalf of the enrollee to petition the commissioner for an expedited external appeal process.

This bill provides these time frames in order to ensure and protect the safety of the patients as well as ensure that physicians are making the medically necessary determinations.

This bill, in summary, also ensures that the individual reviewing this information on behalf of whether it's the insurer or the review company has a similar or same background as the provider providing those services, ensuring that the clinical decisions are based upon sound judgment and expertise associated with the services necessarily being provided to the patient.

Thank you very much, and I'd be happy to answer any of your questions.

REP. FONTANA: Thank you, Matt, and if I could, I'd just like to ask you about a brief bill.

MATTHEW KATZ: We submitted testimony. Happy to answer any questions.

REP. FONTANA: Great.

When we were talking about the consumer report cards and the transparency of data, Christine mentioned the NCQA and the HEDIS standard.

HB6530

Seeing none, we will move on Senate Bill 958 and Matt Katz.

MATTHEW KATZ: Senator Crisco, Representative Fontana and members of the Insurance and Real Estate Committee, again, my name is Matthew Katz. I'm the executive vice president of the Connecticut State Medical Society. And on behalf of our more than 7,000 members, thank you for the opportunity to present testimony today in support of Senate Bill 958, An Act Concerning Utilization Review.

Though this bill is very similar to the previous bill that we talked about, 959, there are some differences, and this bill is necessary. We appreciate the effort of the committee in clarifying the requirements and standards for utilization review companies and the review such companies perform tied to managed care -- excuse me, medical care provided to patients.

CSMS believes that the most -- for the most part this bill does assist physicians and more importantly their patients in the quest to have treatment determinations made in a prompt fashion and to ensure that treatment assessments are not overruled after medical care has been provided as long as the appropriate information has been provided at the time of utilization review.

The bill redefines utilization review to include retrospective assessments of the necessity and appropriateness of the allocation of healthcare services given or proposed to a patient. We believe that this further protects patients receiving care as well as the physicians who provide medically

necessary care.

This bill creates a new definition of "adverse determination," however it is very different than the Raised Bill 959 definition. We would ask that these definitions are similar -- in fact, the same -- and we ask that we -- that you use the information in the previous Raised Bill 959 because it references a covered benefit associated with that determination.

The bill also adopts a definition of "medical necessity" consistent with the state definition, and the definition from the MDL Managed Care lawsuit settlement agreement between physicians and most of the nation's health insurers.

The bill also clarifies that after a prospective determination is made and communicated, that the company -- the utilization review company shall not reverse such determination unless missing or inaccurate information was provided at the time that its review was initiated.

In addition, the bill requires adverse determination to be made by a licensed health professional. We strongly recommend adding language to clarify that the licensed healthcare professional must have expertise in that clinical area. It is critical for the care of the patient and the review of that claim that the healthcare professional has that expertise.

The bill shortens the time frames within which a utilization review company must notify an enrollee. Unfortunately, it doesn't indicate it anywhere or specify that any type of review or required additional information would

suspend, pend or even delete that time frame, and we're concerned about the gaming in the system that may take place.

And I further recommend that there be some specificity provided, such as a response period, so that it doesn't get delayed in perpetuity.

Finally, we think it's important that this bill imposes specific time frames to ensure that determinations are not only made but appeals can be initiated by patients as well as their physicians and other providers, and we believe it's important that those determinations have a period of time that allows adequate and appropriate review both by the patient and the physician.

Thank you very much.

REP. FONTANA: Thank you, mat. Are the specific points you raised in your testimony?

MATTHEW KATZ: Yes.

The written testimony goes into much more detail associated with what we consider the anti-gaming components, as well as the need for clearer definition of the clinical provider reviewing -- healthcare professional reviewing the claims, the specific time frames, as well as the adverse determination language, which is slightly different between the two bills heard before you today associated with appeals and utilization review.

And, Mr. Chairman, if I might add, one of the things that we were talking about in the earlier bill had to do with transparency. We

believe that one of the paramount components of transparency is better understanding and defining the medical loss ratio, and we know that there are bills in this house, in this assembly, that attempt to do that.

And we adamantly and strongly support those to ensure that, again, there is a standard definition of medical loss and that employers and patients, as well as providers, understand where the healthcare dollar is going and where it's not going.

REP. FONTANA: And are there any definitions out there proposed bills or in law on the medical loss ratio that you particularly like or don't like?

MATTHEW KATZ: We can submit to the committee information provided by the American Medical Association that I think more accurately and clearly -- we may have provided some of that in our testimony, written testimony today, a definition of medical loss ratio that defines what is administrative, what is clinical and medical, and how best to standardize the process so that one insurer and another insurer have the same standard so when a patient, an employer or a physician is looking at whether they're contracting to be a provider or contracting to have health insurance, those individuals understand what percentage of the healthcare dollar is going to true medical care and what is going to what is truly defined as administrative expenses.

REP. FONTANA: Very good. We'll look forward to seeing what you've got and hopefully get ideas from the commissioner and other people as well --

MATTHEW KATZ: Thank you, Mr. Chairman.

REP. FONTANA: -- what constitutes a medical loss ratio.

Questions for Matt from members of the committee? Thank you very much, Matt.

MATTHEW KATZ: Thank you.

REP. FONTANA: Susan Halpin, followed by Brian Quigley.

SUSAN HALPIN: Good afternoon, chairman Crisco, Chairman Fontana, members of the committee. I'm Susan Halpin on behalf of the Connecticut Association of Health Plans to testify in opposition to Senate Bill 958, An Act Concerning Utilization Review.

We urge your strong opposition to this legislation. There are a number of provisions incorporated within that we think are highly problematic in an incredibly complex and complicated bill. And I would be happy to give you further comment at a later time.

But for purposes of medical necessity issue, Connecticut's recognized as a leader in the area of medical necessity determinations by virtue of the 1999 managed care act which instituted an independent third-party external appeal mechanism for both consumers and providers.

Matters of question are forwarded to the Department of Insurance via the Department of Insurance to an outside entity made up of physicians within the specialty practice in question. They review all relevant information from both sides and issue a

REP. ALTOBELLO: Collect millions of dollars in premiums?

THOMAS SULLIVAN: -- and roll out tomorrow. Very little patrol.

REP. ALTOBELLO: Thank you. thank you, Mr. Chairman.

REP. FONTANA: Thank you, Representative. Other questions for the commission another on House Bill 6529? Seeing none, Commissioner, please proceed to the next one.

THOMAS SULLIVAN: Thank you.

And the final bill on the hit parade is Senate Bill 959, Raised Bill 959, An Act Concerning External Appeals. Again, I would like to thank the committee for raising the bill on behalf of the department.

Raised Bill 959 enhances the Insurance Department's external appeals program by adopting the NAIC model law provisions on expedited appeals, firming up quality control standards and clarifying situations when a provider may initiate an appeal. Current law on external appeals will be maintained which is much stronger and provides consumer protections above and beyond the NAIC model law.

The changes proposed are enhancements and clarifications that will further improve consumer protections.

More than 200 Connecticut residents per year take advantage of the Insurance Department's external appeals program. These appeals are filed by consumers when health insurers,

managed care organizations or utilization review companies deny a health claim based on medical necessity or determine not to certify a hospital admission, medical service or medical procedure or the extension of a hospital stay.

In 2008, 211 residents filed external appeals with our office. Of those accepted for review, the company's claim decision was either reversed or partially reversed in 45 percent of these cases while the company's decision was upheld by the independent review entity in 56 percent of the appeals.

Raised Bill 959 improves current law by adopting provisions for expedited external reviews when needed in life-threatening and emergency situations and adopting the NAIC standards on the selection process of external review entities. These include quality controls, ability to meet time frames and to electronically receive data after hours, as well as standards for clinical expertise and confidentiality standards, imposing data reporting requirements and clarifying that the provider may initiate an external appeal for an enrollee without receiving the enrollee's explicit consent.

Once again, thank you for raising the bill on the department's behalf, and I would take any questions from the committee.

REP. FONTANA: Thank you, Commissioner. And are you are you seeing any sort of increase in the number of people availing themselves of the external appeal process or is it pretty much a stable (inaudible) of people?

THOMAS SULLIVAN: It's fairly stable. I would

actually say it's on the decline. One of the things the department continues to monitor is that we do not get continued external appeals for the same types of treatments, because if there's a pattern with one particular provider, then we obviously have a problem.

If they're denying care, you know, for the same type of treatment and it's the same provider, that would be something that we would probe and look at.

But I'm pleased to report that it's relatively stable and it's actually on a slight decline.

REP. FONTANA: And again, I believe you indicated this is revising our law to comport with the NAIC model act? Is that --

THOMAS SULLIVAN: Yes. As a matter of fact, the NAIC model was effectively built off of the Connecticut legislation. Once again, this fine committee and this -- the people in this grand building were pioneers in terms of some of the consumer protections we provided in our initial law.

The NAIC model builds on our current Connecticut law. As I mentioned, you know, some of the selection criteria around the review (inaudible) and confidentiality provisions and some of the other things I think strengthen the legislation even further.

REP. FONTANA: Very good. Thank you. Questions for Commissioner Sullivan on Senate Bill 959? Seeing none, I think you're all set. At least for the time being.

THOMAS SULLIVAN: Okay.

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Testimony of the Connecticut Insurance Department

Before
The Insurance and Real Estate Committee

Tuesday, February 24, 2009

Raised Bill 958--An Act Concerning Utilization Review

The Insurance Department has significant concerns with this bill as drafted, and believes some of the changes may have unintended consequences that are not in consumers' best interests. SB959

The bill deletes language that a clarification of coverage is not utilization review. We are not sure of the intent of the provision but it appears to include issues not related to medical necessity under the utilization review law. We believe the utilization review laws should continue to relate to medical necessity issues which also ties in with the external appeal law (as noted later in this testimony). If there are other issues, perhaps contract exclusions, that need more scrutiny, we suggest that such issues be clearly identified, and if appropriate, included in other legislation, rather than amend the utilization review law to include items that "don't fit." If the intent is to expand the law to include contractual denials, we believe this will disadvantage Connecticut group policyholders which have specifically negotiated and contracted with their group health insurer for specific benefits and specific exclusions. Such an expansion may override contract terms and change the benefit design that an employer has selected and paid for. Again, we believe the external review laws should continue to apply to medical necessity issues where there can be differing medical opinions, based on the individual clinical situation of a patient and what is appropriate treatment, based on the patient's condition, in view of latest medical advances, clinical trials, and other relevant medical factors, and not to clear contract exclusions applied uniformly to all insureds covered the policy.

Another major impact is that this bill changes the definition of utilization review to include retrospective reviews. This change will dramatically increase the number of entities that will need utilization review licenses. The Department does not believe this expansion is needed because existing laws (Section 38a-478m and 478n, C.G.S.), already provide requirements for retrospective reviews involving medical necessity. With this change, all insurance carriers that write health insurance in the state and entities that process claims will now require a utilization review license. This potentially increases the number of applications processed annually from 120 to more than 500 and will require additional resource to the Department for the licensing, annual data collection, and market conduct examination of these entities.

The requirement that all utilization review determinations be written, albeit well-intended, could delay the notification to enrollees and providers. Currently only denials are required to be in writing. Approvals require a confirmation number, but may be transmitted other than in writing, such as by telephone, facsimile, or email. This enables the enrollee and provider to immediately begin the approved treatment.

The Department is particularly concerned about the written requirement for expedited reviews in life-threatening situations where time if of the essence, and again a faster approval can lead to immediate treatment. (Note: the Department recognizes that the bill permits a utilization review entity to do an optional non-written notice in addition to the required written notice, but we are concerned that many entities may not do both). The Committee should be aware that Raised Bill 959, the Department's proposal on External Appeals includes provisions related to expedited review.

The bill eliminates the requirement that a copy of the external appeal application and brochure be included with the final denial notice. We believe this change is adverse to consumers, since including the application along with a brochure with the final denial notice allows enrollees to quickly and easily begin the external appeal process. The consumer has a 60 day window to apply for external appeal, and we believe it is prudent for the consumer to act expeditiously and not delay and take a chance on missing the 60 day window. Current law helps the consumer in this regard.

The bill also modifies the external appeals process. The intent appears to be to eliminate the application fee for the enrollee or provider. The Department believes the nominal application fee ($25), except for the indigent, should remain in place to discourage requests that may be unnecessary or without merit for external appeals. There is a cost factor in paying a review entity for each external appeal, and it is desirable to incur such cost only where appropriate and necessary

If this bill moves forward, the Department suggests using the same definition of adverse determination that is in Raised Bill 959. That way the utilization review requirements and the external appeal requirements will be consistent. Final utilization review determinations are eligible for an external appeal, so it is important for the two laws to operate in tandem.

The Department also believes the hearing process, while well-intentioned, raises a host of issues, including: (1) privacy issues, (2) ownership issues, (3) who may access the data, (4) how long must the data be maintained, and, (5) who bears what costs. , etc.

For the reasons noted above, the Department urges the Committee to oppose this bill.

160 St Ronan Street, New Haven, CT 06511-2390 (203) 865-0587 FAX (203) 865-4997

Connecticut State Medical Society
Testimony in Support of Senate Bill 958 An Act Concerning Utilization Review
Insurance and Real Estate Committee
February 24, 2009

Senate Crisco, Representative Fontana and members of the Insurance and Real Estate Committee, my name is Matthew Katz and I am the Executive Vice President of the Connecticut State Medical Society (CSMS). On behalf of our more than 7,000 members thank you for the opportunity to present this testimony to you today in support of Senate Bill 95 An Act Concerning Utilization Review.

We appreciate the effort of the committee to clarify the requirements and standards for utilization review companies and the reviews such companies perform tied to medical care provided to patients. CSMS believes that for the most part, this Bill assists physicians and more importantly their patients in the quest to have treatment determinations made in a prompt fashion, and to ensure that treatment assessments are not overruled after medical care has been provided, as long as appropriate information is provided at the time utilization review is performed.

This bill redefines "utilization review" to include *retrospective* assessments of the necessity and appropriateness of the allocation of the health care services given or proposed to be given to a patient. Under the current definition, utilization review includes prospective and concurrent assessments. We believe that this further protects the patients receiving the care and the physicians who provide the medically necessary care.

The bill creates a new definition for "adverse determination" which differs from the new definition set forth in Raised Bill No. 959, An Act Concerning External Appeals of Adverse Determinations by a Managed Care Organization, Health Insurer, or Utilization Review Company. We believe that he definition contained in Raised Bill No. 959 should replace the definition of "adverse determination" proposed in this bill because it specifies that the determination relates to a *covered* benefit. Raised Bill No. 959's definition of "adverse determination" states as follows:

> A determination by a managed care organization, health insurer or utilization review company that an admission, service, procedure or extension of stay that is a covered benefit has been reviewed and, based on the information provided, does not meet the managed care organization's, health insurer's or utilization review company's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and such requested, or payment for such,

admission, service, procedure or extension of stay has been denied, reduced or terminated.

The bill also adopts the definition of "medically necessary" and "medical necessity" contained in the *In re Managed Care* settlement agreements and in existing Connecticut statute.

The bill also clarifies that after a prospective determination that authorizes a procedure has been communicated by the utilization review company to the provider/enrollee, the company shall not reverse such determination if such procedure has taken place in reliance on such determination, unless the determination was based on inaccurate information from the provider.

If a physician requests a concurrent determination, the bill would require the utilization review company to provide, if requested by the physician, an opportunity for such physician to discuss the request for concurrent determination with the health care professional making the determination. This is very important when dealing with time sensitive and medically necessary patient care.

In addition, the bill requires any adverse determination to be made by a licensed health care professional. We strongly recommend adding language to clarify that the licensed health care professional must have expertise in the clinical area in question.

The bill shortens the timeframe within which a utilization review company must notify the enrollee and physician of its determination from no later than thirty days to no later than fifteen days. Despite this shorter time period, nothing appears to prevent the companies from "gaming" the system through delay tactics (e.g., repeated requests for additional information). We recommend that a company be entitled to no more than two requests for information, and that the fifteen day response period be extended by no more than five days in the event a second information request is necessary.

The bill would require utilization review companies to use clinical criteria and review procedures consistent with the amended definition of "medical necessity" which further supports patient care and a physician's medical necessity determination.

Under present law, utilization review companies may include, but do not have to include, a reasonable period within which a patient or physician can file an appeal for an adverse determination. This bill imposes a specific time period of not less than ninety days after the issuance of an adverse determination within which to file an appeal. We believe that this allows the patient and the patient's physician to more effectively and appropriately appeal any adverse determination.

This bill also shortens the time period within which the utilization review company must complete the adjudication from two days to not later than one business day after the date the appeal is filed and all information necessary to complete the appeal is received by the company. Given our concern for continued gaming of the system of utilization review, we recommend that the same "anti-gaming" provision suggested above be included in this section as well to safeguard the process and prevent abuse.

Finally, if adjudication upholds an adverse determination, the company shall notify the enrollee/enrollee's provider. In the case of a final adjudication, the notice shall contain the procedure to appeal to the commissioner pursuant to Conn. Gen. Stat. § 38a-478n. Under the current law, an enrollee or provider acting on behalf of the enrollee who has exhausted all internal appeal mechanisms, may appeal an adverse determination to the commissioner within sixty days after receiving final written notice of the determination.

The bill before you today, with the suggested amendments would appropriately strengthen our current Utilization Review law, providing a more equitable system for both patients and physicians. Please support SB 959

Connecticut State Medical Society
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160 St. Ronan Street, New Haven, CT 06511-2390 (203) 865-0587 FAX (203) 865-4997

Connecticut State Medical Society
Testimony in Support of Senate Bill 959 An Act Concerning External Appeals of Adverse Determination By A Managed Care Organization, Health Insurer or Utilization Review Company
Insurance and Real Estate Committee
February 24, 2009

Senate Crisco, Representative Fontana and members of the Insurance and Real Estate Committee, my name is Matthew Katz and I am the Executive Vice President of the Connecticut State Medical Society (CSMS). On behalf of our more than 7,000 members thank you for the opportunity to present this testimony to you today in support of Senate Bill 959 An Act Concerning External Appeals of Adverse Determination By A Managed Care Organization, Health Insurer or Utilization Review Company. This bill provides expanded benefits to consumers while improving transparency, and contracting and performance oversight of third-party administrators. CSMS believes that this bill provides physicians with the necessary tools to advocate for their patient's medically necessary care when a health insurer or other entity initially denies such medical care. A physician's determination of what is and is not medically necessary is paramount to ensuring quality patient medical care.

The bill creates a new definition for "adverse determination" which states as follows:

> A determination by a managed care organization, health insurer or utilization review company that an admission, service, procedure or extension of stay that is a covered benefit has been reviewed and, based on the information provided, does not meet the managed care organization's, health insurer's or utilization review company's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and such requested, or payment for such, admission, service, procedure or extension of stay has been denied, reduced or terminated.

Under the current law, an enrollee (or a provider acting on behalf of an enrollee) who has exhausted all internal appeal mechanisms, may appeal an adverse determination to the commissioner within sixty days after receiving written notice of such determination. Upon receipt of an appeal, the commissioner shall assign the appeal for review to a review entity. The current law also permits the commissioner, after receiving three or more appeals of denials or determinations by the same managed care organization or utilization review company with respect to the same procedural or diagnostic coding, to issue an order specifying how such company shall make determinations about such procedural diagnostic coding.

This bill requires the managed care organization, health insurer or utilization review company, not later than five days after receipt of notification by the commissioner of the appeal, to provide to the review entity all documents and information that were considered in making the adverse determination.

The bill would permit an enrollee (or a provider acting on behalf of an enrollee) to petition the commissioner for an *expedited* external appeal at the time the enrollee receives an adverse determination provided that certain enumerated conditions set forth in the bill have been met. The bill further provides that, upon receipt of a request for an expedited external appeal and all required documentation, the commissioner shall immediately assign the appeal for review to a review entity. The review entity must conduct a preliminary review of the appeal not later than two business days after receipt of such appeal from the commissioner.

If the review entity accepts the appeal for review, such review must be performed by a provider who is a specialist in the field related to the condition that is the subject of the appeal. Having a provider who specializes in the care being provided or attempting to be provided is critical in making sure that the patient's medical needs are considered and the specific medical care is appropriately considered and evaluated. The bill further requires the review entity to complete its full review of an expedited appeal not later than two business days after the completion of its preliminary review and shall forward its decision to the commissioner.

The managed care organization, health insurer or utilization review company, not later than one business day after receiving notice from the commissioner of the receipt of a request for an expedited external appeal, shall provide to the assigned review company all documents and information that were considered in making the adverse determination.

Under the proposed bill, the commissioner shall assign review entities to appeals on a random basis and shall choose such entities from among those approved by the Insurance Commissioner, after consultation with the Commissioner of Public Health. We believe that this provides a further layer of protection and prevents any potential conflicts of interest.

The bill also sets forth the eligibility requirements for approval by the commissioner and provides that each approval shall be effective for two years, unless the commissioner determines before its expiration that the review entity is not satisfying the minimum qualifications set forth in this bill. This is an important provision in the proposed bill.

Finally, CSMS supports the principle of minimum qualifications for each clinical reviewer assigned by a review entity to conduct external appeals as set forth in this bill. For example, the clinical reviewer must be an expert in the treatment of the enrollee's medical condition that is the subject of the external appeal.

Thank you for the opportunity to provide this information to you today. Please support Senate Bill 959.

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Testimony of Thomas R. Sullivan

Commissioner of the Connecticut Insurance Department

Before the

Insurance and Real Estate Committee

Tuesday, February 24th, 2009

Raised Bill 959—An Act Concerning External Appeals of Adverse Determinations by a Managed Care Organization, Health Insurer or Utilization Review Company

Raised Bill 959—An Act Concerning External Appeals of Adverse Determinations by a Managed Care Organization, Health Insurer or Utilization Review Company has been raised at the request of the Connecticut Insurance Department. The Department would like to thank the Co-Chairman of the Insurance and Real Estate Committee for raising this bill on our behalf.

Raised Bill 959 enhances the Insurance Department's external appeals program by adopting the National Association of Insurance Commissioners (NAIC) Model Law's provisions on expedited appeals, firming up quality control standards and clarifying situations when a provider may initiate an appeal. Current law on external appeals will be maintained which include stronger protections than those in the NAIC Model Law. The changes proposed are enhancements and clarifications that will further improve consumer protections.

More than 200 Connecticut residents per year take advantage of the Insurance Department's external appeals program to appeal denials by health insurers, managed care organizations or utilization review companies of health claims based on medical necessity; or determinations based on medical necessity determinations not to certify a hospital admission, medical service, medical procedure or extension of a hospital stay. In 2008, 211 residents filed external appeals; and of those meeting statutory requirements and accepted for review, the payor's claim decision was either reversed or partially reversed in 45% of the cases, while the payor's decision was affirmed by the independent review entity in 56% of the appeals reviewed.

Among the improvements over the present external appeals statutes:

- It adopts provisions for expedited external reviews when needed in life threatening and emergency situations.
- It adopts NAIC standards on standards and the selection process of external review entities. These standards include quality controls, ability to meet time frames and to electronically receive data after hours, standards of clinical expertise, and confidentiality standards.
- It adopts NAIC data reporting requirements.

- It clarifies that a provider may initiate an external appeal for an enrollee without receiving the enrollee's explicit consent.

Once again, thank you for raising this bill on the Department's behalf and we would ask that you support this proposal. We would be happy to answer any questions you may have.