**PA10-24**

HB5235

| | | |
|---|---|---|
| House | 884-892 | 9 |
| Insurance | 830, 832, 878-884, 915-917, 934-936, 977, 981, 990-991, 994-995, 1052-1055 | 25 |
| Senate | 1281-1285, 1315-1316 | 7 |
| | | **41** |

**H – 1076**

# CONNECTICUT
# GENERAL ASSEMBLY
# HOUSE

## PROCEEDINGS
## 2010

**VOL.53**
**PART 3**
**595 – 894**

Those absent and not voting 5

DEPUTY SPEAKER GODFREY:

The bill as amended is passed.

The House will stand at ease.

(Chamber at ease.)

DEPUTY SPEAKER GODFREY:

The House will come back to order.

Mr. Clerk, kindly call Calendar 131.

THE CLERK:

On page 8, Calendar 131, Substitute for House Bill Number 5235, AN ACT REQUIRING THE PROVIDING OF CERTAIN INFORMATION UPON CERTAIN DENIALS OF HEALTH INSURANCE COVERAGE, favorable report by the Committee on Insurance.

DEPUTY SPEAKER GODFREY:

Distinguished Chairman of the Insurance and Real Estate Committee, 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.

DEPUTY SPEAKER GODFREY:

The question is on passage.

Representative Fontana.

REP. FONTANA (87th):

Thank you, Mr. Speaker.

Mr. Speaker, this bill requires health insurers who deny coverage for a requested service, either because it is not medically necessary or not a covered benefit, to notify an insured of his or her ability to contact the Office of the Healthcare Advocate if the insured believes that that health insurer has given him or her erroneous information.

Health insurers must also provide the insured with the contact information for that office. This bill does not conflict with or supplant our existing external appeals process for a claim denial as described in Connecticut General Statute, Section 38a-478n.

That statute gives an insured the right, under specific circumstances, to apply for an external appeal for coverage of medical services or supplies denied to that insured by his or her insurer on the basis of not being medically necessary.

Rather, this bill compliments that process by indicating to an insured that the healthcare advocate

may assist him or her in understanding and navigating existing processes for resolving coverage and claim disputes.

I urge passage.

DEPUTY SPEAKER GODFREY:

Thank you, sir.

Will you remark further on the bill?

The gentleman from East Woodstock, Representative Alberts.

REP. ALBERTS (50th):

Thank you, Mr. Speaker.

Through you, a question if I may, to the proponent of the bill?

DEPUTY SPEAKER GODFREY:

Please frame your question, sir.

REP. ALBERTS (50th):

Thank you, Mr. Speaker.

As I was looking at the document, it occurred to me that there was no fiscal note on this. And I just want to make sure that there is no fiscal impact either to the State or to municipalities. Is that not correct? Through you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Fontana, do you care to respond?

REP. FONTANA (87th):

Thank you, Mr. Speaker.

The gentleman is correct. According to our fiscal note there is neither any State or municipal impact.

Through you.

DEPUTY SPEAKER GODFREY:

Representative Alberts.

REP. ALBERTS (50th):

Thank you, Mr. Speaker.

That is as I understood as well. We stand in support of this bill. I urge my colleagues to support it today.

Thank you.

DEPUTY SPEAKER GODFREY:

Thank you, sir.

The gentleman from West Hartford, Representative Fleischmann.

REP. FLEISCHMANN (18th):

Thank you, Mr. Speaker.

Mr. Speaker, I rise in support of this measure and I'd like to start by thanking the Insurance Committee leadership, both the House and Senate Chair, the House and Senate ranking members -- tony D'Amelio

isn't here today and Mike Alberts, who's standing in for being in support of this measure.

It's a common sense bill. It simply makes sure that people who have been denied coverage for medical procedures know that they can contact the Office of Healthcare Advocate and pursue appeals if they feel that that's appropriate.

Some might ask why we should do this bill. Mistaken denials of coverage do happen. Many times here in my service in the Assembly, I've heard from constituents who were denied coverage and are shocked by it. And I, like many of you, have helped them to get redress, to get the proper appeal and to get coverage. And often this is coverage that is included in their plan and I've experienced this personally.

Like many here I had the good luck to marry someone who was smarter and more foresighted than I. And when it was time to sign up for an insurance plan we signed up for the point of service plan, the fanciest plan, because as my wife pointed out, you never know what's going to happen in life and you should have the best possible coverage.

When I received a surprise diagnosis last year, my Hartford area physician recommended that the best

people in the world that I should talk to about my diagnosis were a surgeon and an oncologist from Memorial Sloan-Kettering in New York City.

So I called the number on the back of my card to just double check that I could go ahead and see those specialists. And a very nice person on the other end of the phone said, I'm sorry sir, but your plan doesn't cover that benefit.

So then my doctor's office from Hartford went and called the insurer to check to see if I could go down to Sloan-Kettering. They were told, sorry, your plan doesn't cover this.

So then Memorial Sloan-Kettering called the insurance company and they were told, sorry, this is not a covered benefit.

So I did for myself what I would do for any constituent who would have contacted me on a matter like this. I got in touch with the government relations person for this insurance company. And I said, I just would like you to look into this. It seems surprising to me. This is the point of service plan. It was my understanding that it had articulation agreements with many of these fine hospitals.

I got a call back shortly thereafter saying, so sorry, you are covered. This is part of your plan and that person who spoke to you, they happened to have it wrong.

And I was grateful, though I had to point out that it wasn't one person who had gotten it wrong. It wasn't two people who had gotten it wrong. It was three different individuals at this insurer who had told three separate inquirers, sorry, not covered.

It's a step forward for us on these denials of coverage to have, just at the bottom of the notice, information that says, by the way, if you think that you are covered you can contact your Office of Healthcare Advocate. Here's the number and they can help you with the internal and external appeals process. It's common sense and it's helpful and it's a good first step.

I'd like to point out that, though, that there is absolutely no cost to any HMO or insurance company that, as a pattern of practice, issues denials when there ought to be coverage. When they're questioned on it, they'll go ahead and provide the coverage, but they really paid no penalty for having denied people coverage that they have paid for already.

So in the long run, I'm hopeful that we'll be able to ascertain better whether there are patterns here, whether there are companies that are consistently denying coverage to residents of the state who have paid for that coverage. Because to me, that's just quite simply wrong. It's a violation of contract and there ought to be consequences.

People should not have to struggle to get the coverage that they have paid for and that their policy provides for. This measure before us provides a nice small first step, a first type of transparency toward getting us toward that goal. I think we'll have a lot more data once this bill is enacted.

Again, I think the Insurance Committee for considering it and moving it forward and I hope all members of the Chamber will join me in a bipartisan fashion, as the Insurance Committee did, in supporting this measure. Thank you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Remark further on the bill? If not, staff and guests please come to the well of the House. Members take your seats. The machine will be open.

THE CLERK:

The House of Representatives is voting by roll

call. Members to the chamber. The House is taking a roll call vote. Members to the chamber, please.

DEPUTY SPEAKER GODFREY:

Have all the members voted? Have all the members voted? All the members having voted, the machine will be locked. The Clerk will take a tally. And the Clerk will announce the tally.

THE CLERK:

House Bill 5235.

| | |
|---|---|
| Total Number voting | 146 |
| Necessary for adoption | 74 |
| Those voting Yea | 146 |
| Those voting Nay | 0 |
| Those absent and not voting | 5 |

DEPUTY SPEAKER GODFREY:

The bill is passed.

The Clerk please call Calendar 149.

THE CLERK:

On page 9, Calendar 149, substitute for House Bill Number 5303, AN ACT CONCERNING REPORTING OF CERTAIN HEALTH INSURANCE CLAIMS DENIAL DATA, favorable report by the Committee on Insurance.

DEPUTY SPEAKER GODFREY:

Representative Fontana.

# JOINT
# STANDING
# COMMITTEE
# HEARINGS

## INSURANCE AND
## REAL ESTATE
## PART 3
## 673 – 1001

## 2010

SENATOR CRISCO: No. You're doing fine, David. Thank you very much.

DAVID FUSCO: Thank you.

SENATOR CRISCO: We appreciate it, and we look forward to working with you.

DAVID FUSCO: Thank you.

SENATOR CRISCO: Since it has gone past 3 o'clock we will now turn to the alternate lists between public and officials. And the next Speaker is Speaker Donovan.

REP. DONOVAN: Well, hello members of the Insurance Committee. Senator Crisco, Representative Fontana, all the members, great to see you. I just want to say it's certainly a pleasure to be here.

I'm here to speak on a number of bills, but I think, particularly, Senate Bill 194, AN ACT CONCERNING RATE APPROVALS FOR INDIVIDUAL HEALTH INSURANCE POLICIES. There's testimony. You should have copies of it. I'll just jump to the second page.

But generally, I think that listening to the back-and-forth, Senator Hartley kind of mentioned, is that we are hearing, and pretty much every day, about the rate increases. And we certainly have some concerns as Legislators to figure out what we can do about it. What can we do about it and try to find out more information.

HB5235
HB5219

And certainly, you know, I would like to juxtapose the rate increases of 20, 30 -- in California, almost 40 percent -- these

care advocate to intervene in rate cases and appeal rate decisions to the superior court. We have the Consumer Council in terms of the utilities. And this would give someone in our -- in our state government a rate -- a way to intervene in those cases.

So I think there are very reasonable requests, so we can provide some answers to the people and maybe find some reasons to approve or not approve that. So I think that's important.

I'd also like to talk about two other bills, the evidence of noncoverage for health insurance. I've heard both from patients and providers concerned about coverage they thought they had, and it turns out maybe they didn't have it, and find out, yes, they did have it. And that -- to clear up that confusion, so that people would know what coverage they have in their health insurance. That's important. HB5235

And then, the other, House Bill 5219, extending the state continuation of health insurance coverage, otherwise known as everybody's COBRA. I think that's a great idea. It helps people who, right now, are going through high unemployment, the chance to continue their health -- their health care, at their cost.

So I think these are three great proposals and I certainly support them. I thank the committee for its -- its hard work now, and in the future, to get these things done.

SENATOR CRISCO: Thank you, sir. Appreciate it.

Questions?

Representative Geragosian.

Representative Fleischmann.

REP. FLEISCHMANN: Chairman Crisco, Chairman Fontana, members of the committee, thank you very much for holding this public hearing and for drafting such good proconsumer legislation to be considered today.

There are three bills on your agenda that I think are all excellent: Senate Bill 194, House Bill 5219, and House Bill 5235. That last measure is one that you drafted at my request, so I thank you for that. And I'd like to comment on it and offer some specifics regarding ways that I think we can take what is really a good bill and make it even stronger.

The bill, AN ACT CONCERNING EVIDENCE OF NONCOVERAGE OF HEALTH INSURANCE, comes out of a personal experience. I, as a state employee had a choice of an array of plans. And like many people, I was good enough to marry someone who is smarter than I was, who explained to me that they plan that we had to have was the point of service plan, the best plan that was available that had the broadest coverage. And that's what I've had ever since I got married.

I got a surprise diagnosis last fall, and was told that the best place for me to go was Sloan-Kettering in New York City where there were specialists who were the tops in the world. So I just called up the number on the back of my insurance card to double-check that I would be covered. And I was told that it was out-of-network, I wasn't covered.

So I had my doctor's office check. And they said oh, sorry, it appears it's out-of-network and you're not covered. Sloan-Kettering checked; same answer.

Now, given who I am, I didn't stop there. And I contacted some folks who were higher up in the organization and they looked into it. And it turned out, in fact, that I was covered. That this was part of the coverage that I had been paying for, for the previous six years, and that the folks who had given those prior answers were mistaken.

Now I mentioned this because I am one of countless people in Connecticut who this has happened to. It just -- and it happens, I'm sure, oftentimes inadvertently. That the person who's at the other end of the line doesn't have the full information on all of the networks that are associated.

But if you think about the policy, how many people are there, who are told, sorry, it's not part of your coverage, and they accept that answer. And then they don't get coverage that they actually have been paying for? We don't know.

The bill that you have put forward gives a good start towards addressing that problem. I would advocate that on line 16, in addition to denials related to something being called "not a covered benefit", that something being called "not medically necessary" be added, because, oftentimes, that not medically necessary rubric is placed on that bill -- I'm sorry, or a request for care unfairly.

With regard to notice, lines 47, 48, you're suggesting notice to both the insurance department and the Office of Healthcare Advocate. I think just having the notice go to the Office of Healthcare Advocate makes sense to me, since they really are the organization

focused on consumers.

And last but not least, I would urge you to consider giving the Office of Healthcare Advocate the power to do something about denials. So specifically, let the healthcare advocate investigate if they see a pattern of watching denials coming from a single company. Let -- give them the power to find that there's been an unfair trade or insurance practice, and take appropriate remedies.

Only in that way can we assure that this stops happening. If there's absolutely no downside to denials for coverage that ought to be there, there's no reason that any rational corporate actor should change their behavior. So I'm just talking about making sure that we have the right incentive structure, so that everybody does what they ought to do.

I'm -- I'm not questioning anyone's motives. I'm just saying we don't have the right incentives right now. There's absolutely no cost to a company that is issuing denials that are inappropriate.

So thank you for raising that bill, for listening to my testimony. And thank you, too, for Senate Bill 194, which I think is great. I would encourage you to consider defining medical expenses, so that there could be no gaming of ratios there.

And House Bill 5219, continuation of health insurance coverage. It's a great bill. In this economy a lot of people need those additional months.

So thank you for all you're doing on all those bills. And I'd be happy to answer any

questions.

SENATOR CRISCO: Thank you, Representative Fleischmann.

Just a comment. Several years ago this committee adopted legislation based on the testimony of a young man who went to all the Boston facilities and could not find a cure to his cancer. And he traveled to Pittsburgh and -- where there was a program that helped him considerably. And he was told there was no coverage because it was out of network. But we did pass legislation several years ago that covers for cancer clinic trials out of network.

So I may -- I would like you to look at that, and see if there's some way, you know, that's being properly interpreted. I'd appreciate that.

REP. FLEISCHMANN: Well, I'll be happy to look into it. Just to -- to be clear, so I wasn't part of any clinical trial or anything like that.

SENATOR CRISCO: I know.]

REP. FLEISCHMANN: And, in fact, my point of service plan has good coverage in Connecticut and has articulation with some of these institutions out of state. So Memorial Sloan-Kettering was just part of my plan.

SENATOR CRISCO: I understand.

REP. FLEISCHMANN: It was part of my plan. But the person who was answering the phone, apparently, didn't know that.

So the problem I'm talking about isn't so much about cancer patients seeking special

treatment, it's about any patient who's being told, sorry, not covered. When, in fact, maybe there is coverage, and someone just -- who is answering the phone doesn't quite understand the coverage they've bought.

SENATOR CRISCO: Well, thank you. It's just that, you know, the process does work when we hear about it.

Any other questions?

Representative Fontana.

REP. FONTANA: Thank you, Mr. Chairman.

Representative Fleischmann, thank you for your testimony. And certainly will look at making the improvements that you suggest. The reason that we left our the issue about the healthcare advocate and making it a QHP violation is that that is one of those huge, radioactive, red flags for a lot of the people who come to this room on regular basis. And we had an extensive hearing last year on opening up the QHP violation statute to private rights of action. And that ran into a formidable wall of opposition.

So I think that, certainly, we'd like to help work with you to give the healthcare advocate the ability to investigate these things, if he isn't already doing so. And, of course, he goes to bat for people when they contact him to get help. But that's one of the issues that's really something, at this point, that's been zealously guarded by the insurance commissioner as a right of action that he has or she has to pursue, and not something more broadly held.

And that's one of the issues that we're going

to have to deal with, if we want to consider going down and making it a broader bill than what's currently there. I just wanted to alert you to that.

REP. FLEISCHMANN: Well, thank you.

REP. FONTANA: That's the concern.

REP. FLEISCHMANN: Since you're chair of this committee, you're more aware of those, sort of, systemic pressures that are out there. Candidly, it doesn't matter so much to me which statute you choose to use to make sure that companies that have a pattern of issuing denials for coverage that people paid for have some penalty for it. And it could go in some other section of statute, as far as I'm concerned.

I just want us to have the right incentive structure. So that there is some downside cost to a company having a pattern of saying, no, when the contract says, yes. Because to me, that's patently illegal. That's a violation of the contract. And it's -- it's pretty unfair to the consumer who paid the premium.

And I'm just trying to make sure that, one way or another, the incentives are set up right. And if it's not through QHP, but through some other statute, that sounds fine to me, so long as we're able to protect the consumer and the patient.

REP. D'AMELIO: And thank you, Mr. Chairman.

And Representative Fleischmann, thank you for being here and bringing this to light for us.

You know, you mentioned in your testimony you

were given, like, two or three different denials. So what was it that -- did you read through your policy, or were you able to contact somebody within the organization? You know, just for the public's knowledge, too. Because this has happened to many of my constituents. And I just would like to -- to know, you know, the process that you took to -- to -- thank God you were covered and things are working out.

REP. FLEISCHMANN: Well, I mean one of the reasons I'm here is because I followed the process that I would follow for any person in my town who contacted me, which is to immediately get in touch with the person who does government affairs for this company up here at the capital and say, listen, I don't know what precisely the situation is, but it had been my understanding that this point of service plan had very broad coverage. And now we're hearing it doesn't cover Sloan-Kettering, which is, you know, a cancer hospital in New York City that a lot of people go to. Could you please look into this for me?

And she was good enough to talk to the medical directors, and learned very quickly, oh, we have an agreement that is covered. The denial was in error. So I followed a process that you probably would follow, which is find the legislative liaison; figure out what's going on.

The reason why I'm here is, because, you know, except for contacting us, most members of the public aren't going to have that kind of entree. So they're not going to know what to do and they should be protected.

A VOICE: (Inaudible.)]

am really grateful that this team is working so diligently on this problem. I really didn't know where to go. I did join the Tolland Chamber of Commerce in order to get coverage, but you have to have two or more members and I'm a one member team. So I am looking into it and I will contact him again. Thank you.

SENATOR CRISCO: And, you know, since we've been in here all day, we're not sure what happened in Washington today. But I think if Congress does anything, they have to do something on pre-existing conditions, which is a very important part of health care reform. But -- so keep that in mind. It's easy to say, keep the faith, because we're not in your situation. But we're -- we're working at it.

Chairman Fontana.

REP. FONTANA: Just thank you for testifying and thank you for introducing us to your brother.

ROBYN B. SURDEL: Thanks.

SENATOR CRISCO: Any other questions of Robyn?

Thank you for hanging in there.

Now, we'll go back to the public sector. Vicki Veltri.

VICKI VELTRI: I don't know what it is, afternoon or evening. Good afternoon, everyone.

I'm here today -- I'm not going to talk about 194 obviously, because Kevin Lembo did that already. But I'm here to testify in favor of H.B. 5235, AN ACT CONCERNING EVIDENCE OF NONCOVERAGE OF HEALTH INSURANCE.

HB5219

Representative Fleischmann, who I really want to commend for bringing this bill forward to the committee, gave you, I think, some suggestions about the language changes which we completely agree with. And I'll just go over a little bit why -- why we think the language should be the way Representative Fleischmann proposed it should be.

The bill requires now that as part of a denial notice for a noncovered service that the consumer be directed through the denial letter to the Insurance Department and our office. We feel strongly that the -- our office should be the office to which consumer denials or consumers are directed in case of denials. It's what we do. It's what we were set up to do.

And it's -- our agency, OHA, is the only state agency that's dedicated solely to consumer assistance work for health insurance denials. Our office was established specifically with the responsibility to walk with consumers through the process and participate in appeals on their behalf.

In 2009, our agency served over 2600 customers and realized savings of 6.7 million. This work was accomplished by three full-time casework staff. In the same year, the Insurance Department, with the five staff, five full-time staff dedicated health care casework, reported 3,000 health cases, and $1.3 million in savings.

We think there's a reason for that difference and that's because we walk consumers through the process all the way. We appear with them at hearings. We help prepare them for their testimony. We will do legal issues if we need

to legal issues. So we would love -- and think it's a great way to get outreach to the consumers, for our names to be on the bottom of a denial letter.

And while I'm here, can I just also say that we support 5219, the extension of the mini COBRA. I think it's a great idea. And as you know, a lot of people are unemployed, without their jobs, and this is the only access they have to quality health insurance. So that's all for my testimony today.

SENATOR CRISCO: Thank you, Vicki.

Any questions of Vicki? No.

Thank you so much for staying with us.

Continue back to the public list. Is Karen still with us? Thank you, Karen. We're all slowly aging through this process.

KAREN SCHUESSLER: There we go. My name is Karen Schuessler and I'm the director of Citizens for Economic Opportunity. CEO is a coalition of community and labor groups addressing health care reform and corporate responsibility.

I strongly support S.B. 194 and believe it is critical to establish procedures for a public hearing prior to any rate approval for individual health insurance policies and to authorize more oversight by the healthcare advocate and/or the Attorney General.

Health insurance is supposed to protect us when we are sick. But people in the individual market are particularly vulnerable as they face skyrocketing costs and shrinking benefits. A recent study by the Commonwealth Fund, a

care providers.

And finally, insurance companies would be required to allow all credentialed APRNs to bill carriers and to be directly reimbursed. This is vital to allow accurate tracking of APRN access and outcome data, as it is rapidly becoming a key public policy assessment point.

That is our support for this bill. Any questions?

SENATOR CRISCO: Thank you, Doctor.

Any questions? Any questions?

Thank you very much.

Dr. Pagano. Is Dr. Pagano here? Back to doctor --

REP. FONTANA: Mahesh Bhaya, on House Bill 5235. And our last testifier.

DR. MAHESH BHAYA: That's a sigh of relief for a lot of people. And I'm not going against the APRN bill this time.

SENATOR CRISCO: We'll leave the best for the last, Doctor.

DR. MAHESH BHAYA: I hope so.

All right. Here we go.

Once again, good afternoon Co-chairmen, Senator Crisco and Representative Fontana. I already gave my introduction before so I'll just skip to the chase.

I'm basically here to support the House

Bill 5235. First, I would like to thank this committee once again for considering a bill that will help improve delivery of health care for Connecticut residents.

Our societies applaud any effort to improve the transparency -- and that has been the buzzword today -- when claims are denied, and this bill supports exactly. It will provide more information to the insured and the provider as to why the claim has been denied. This will cut down the frustration in patients, which we see and feel every day when the claim is denied without any explanation. This will also help standardize and regulate the timely response for a denial of service.

The insurance industry has enough computing power at its disposal, so it is hard to imagine that a rapid determination of coverage is not possible, especially considering that human lives and suffering are often on the line. We agree with the Office of Healthcare Advocacy that this service should be extended to all denial notices, including those based on medical necessity.

Finally, the requirement that patients who received a denial also receive information on how to contact the Insurance Department and the Office of Healthcare Advocate for assistance on the denial, is both welcome and needed. And from previous testimonies, from Representative Fleischmann, I know that's really important. Because, as a physician, it will be hard for me to find a place to go to if I had a problem with my insurance policy. So for the common laypeople, it's really -- really tough in these times.

This would stand as a buttress for supporting

the weak and the infirm who should be concentrating their efforts on health, and not on lengthy insurance forms and declarations.

And closely -- in closing, we strongly support this bill for the transparency and advocacy this bill seeks for Connecticut residents.

Thank you once again.

SENATOR CRISCO: (Inaudible) Doctor, for sticking with us.

Are there any questions of the doctor?

We appreciate it. Thank you very much.

Is there anybody else that would like to speak? If not, this concludes our public hearing for today. Thank you all very much. Thanks to our staff. Thanks to our legal counsel for their endurance.

FTR
194

CEA
Advocating for teachers and public education

Connecticut Education Association

Governance
Philip Apruzzese, President
Sheila Cohen, Vice President
Cheryl Prevost, Secretary
Jeff Leake, Treasurer
Maureen Horan, NEA Director
Tom Nicholas, NEA Director

Executive Office
Dr. John Yrchik
Executive Director

Government Relations
Mark Waxenberg, Director
Capitol Place, Suite 500
21 Oak Street
Hartford, CT 06106-8001
860-525-5641, 800-842-4316
Fax: 860-725-6362
www.cea.org

Affiliated with the National Education Association

***Testimony of***
***Mark Waxenberg, Director Government Relations***
***Connecticut Education Association***

*Before the*

***Insurance and Real Estate Committee***

*February 25, 2010*

Good afternoon Senator Crisco, Representative Fontana and members of the Insurance and Real Estate Committee. My name is Mark Waxenberg, Director of Government Relations of the Connecticut Education Association, representing over 40,000 members.

I am hear to speak in favor and comment on Senate Bill #194 'An Act Concerning Rate Approvals for Individual Health Insurance Policies', Senate Bill #5235 'An Act Concerning Evidence of Non-Coverage of Health Insurance', and House Bill #5219 'An Act Extending State Continuation of Health Insurance Coverage'.

I am not appearing before you as a healthcare expert, actuary or broker. I am here as a consumer and a resident of Connecticut representing over 40,000 consumers and residents of Connecticut asking for more transparency and accountability within the healthcare industry.

Everyone agrees that healthcare reform is needed, but we disagree with what reform is needed. We should all be able to agree, that as we work toward consensus on healthcare reform, we can inject more transparency and accountability into the present healthcare system.

As premiums increase at double digit rates, as more citizens lose health insurance coverage, and as more citizens have claims denied by insurance companies, it is now time to take a deep breath and examine the cost drivers and reasons for decisions being made by health insurance companies.

The proposed legislation just lets the citizens of our state know what they are paying for and/or why they are being denied claims.

As decisions are made by health insurance companies and/or state officials dealing with increased costs or reducing coverage of healthcare for its citizens, it should not be difficult for them to address the question "why".

In conclusion, I would ask that the Insurance and Real Estate Committee vote in favor of Senate Bill #194, Senate Bill #5235 and House Bill #5219.

Thank You.

000981
194
FTR

Bridgeport Child Advocacy Coalition Testimony to
Insurance and Real Estate Committee

The Bridgeport Child Advocacy Coalition (BCAC) appreciates the opportunity to submit testimony to the Insurance and Real Estate Committee of the 2010 General Assembly.

**BCAC strongly urges support for:**

**S.B. 94: An Act Concerning Rate Approvals for Individual Health Insurance Policies.**

Health insurance premiums are skyrocketing out of control. Our own nonprofit organization suffered a rate increase of 35%. More and more Connecticut residents cannot afford the rising cost of health insurance premiums and are dropping coverage. Those without health insurance are likely to delay going to the doctor or filling a prescription until they are in crisis and end up in the emergency room, at a much greater cost.

SB 94 will ensure that public hearings are held to allow for the public to comment on proposed health insurance rate increases. Specifically, S.B. 94 will:

- Eliminate the health insurance companies' ability to allow rate hikes to take effect without a public hearing.
- Require insurance companies to notify all policyholders of requests for rate increases, and the date, place, and time of the public hearing.
- Require insurers to disclose documentation in support of rate increases for public scrutiny.
- Limit reasons for a rate increase, and puts burden of proving that an increase is "reasonable" on the insurer.
- Empower the Attorney General and the state Healthcare Advocate to intervene in rate cases and appeal rate decisions to the Superior Court.

**H.B. 5235: An Act Concerning Evidence of Non-Coverage of Health Insurance**

Despite having health insurance, claims are denied, often with no reason cited. Too many consumers whose claims are denied are not aware of their legal recourse. They end up having to cover the denied claim at great cost even when the claim might have been denied in error.

Specifically, H.B. 5235 will:

- Require insurance companies to notify consumers in writing that a claim has been denied, include the relevant provision of the insurance policy, and instruct the consumer to contact the Office of the Healthcare Advocate for assistance with an appeal.

**H.B. 5219 An Act Extending State Continuation of Health Insurance Coverage**

The unemployment rate keeps rising. In December, the unemployment rate in Bridgeport was 12.7%. Many of those who lose their jobs also lose their health insurance benefits. Extending COBRA would enable the unemployed to have continuity of health benefit coverage while they are looking for work.

000990

194
5219
5235
FTR

**Testimony of AARP,**
**on S.B. 194, H.B. 5219, & S.B. 5235**
**Insurance and Real Estate Committee**
**February 25, 2010**

AARP is a nonprofit, non-partisan membership organization that serves people 50 and older. We have approximately 40 million members nationwide and over 600,000 in Connecticut. AARP is proud to support the health care reform proposals contained in S.B. 194, H.B. 5219, and H.B. 5235. We commend Chairmen Fontana and Crisco both for taking a strong leadership role in bringing crucial health insurance reform proposals before the Committee.

Private insurance options under the current health care system are deteriorating. Comprehensive health reform, if enacted, is likely to address many of the shortcomings of the current system for high-cost populations and AARP continues to work at the federal level to advocate for health insurance reforms that will protect guaranteed Medicare benefits, restrict "age-rating" for our members age 50-64, close the Medicare Part D "doughnut" hole and end abusive insurance practices. However, in the absence of such reforms, there continues to be a compelling and immediate public interest in increasing access to coverage and AARP commends the leadership of this Committee for continuing to move forward on state-based health care reform.

**S. B. 194, AAC Rate Approvals for Individual Health Insurance Policies**

AARP supports S.B. 194, which will provide better oversight for insurance rate requests. The bill establishes procedure for conducting a hearing prior to any rate approval for individual health insurance policies. S.B. 194 also allows the Attorney General and the Health Care Advocate to be parties in that proceeding. Additionally, the proposed legislation changes the standard by which health insurance premium increases will be measured. Under current law, the Insurance Commissioner may approve any rate increase that is "not excessive, inadequate or unfairly discriminatory." However, S.B. 194 would require the Commissioner to approve a rate increase only if "reasonable," as defined in section 2 of the bill. The "reasonable" standard should provide the Commissioner additional flexibility to reject or reduce a requested rate increase.

Just last summer, Anthem requested a 32% increase on individual policies in Connecticut. The proposal would have increased health insurance costs on approximately 56,000 Connecticut residents. Even under intense public pressure, the Insurance Department ultimately approved a significant 16-20% rate hike. Costly, unexpected rate hikes like these are especially problematic for older adults aged 50-64, who already struggle to find affordable health insurance.

Today, many Americans age 50-64 cannot find affordable coverage because insurers in most states, including Connecticut, charge much higher rates based on age. That is a key reason why 10.4% (or 70,405) Connecticut residents age 50-64 were uninsured in 2007 – a figure that is growing rapidly in our current difficult economy. Even those with insurance often struggle with high premiums and cost sharing obligations that can make health care unaffordable. Without strong procedures and consumer protections, the insurance industry can impose sudden and drastic increases for individual insurance policies, making them unaffordable to many more, older adults. AARP urges the Committee's support of S.B. 194.

**H. B. 5219,AA Extending State Continuation of Health Insurance Coverage**

AARP also supports H.B. 5219; expanding COBRA coverage from 18 months to 30 months, as outlined in H.B. 5219, would extend periods of eligibility and would help provide affordable coverage to adults aged 50 to 64, or "prime age" adults, who have lost their jobs. The high unemployment rate and deteriorating job market has left many individuals without employer-based health care coverage. For older adults between the ages of 50 to 64, loosing health care coverage is particularly devastating because insurance companies, in states like Connecticut, are allowed to charge older individuals several times more for the same insurance policy purchased by younger individuals. Although not yet eligible for Medicare coverage, prime age adults have reached a time when many chronic diseases, which require regular medical attention and can lead to catastrophic spending, begin to develop.

H.B. 5219 could reduce the premium costs for older individuals not yet qualified for Medicare because they would be pooled with lower-risk employees and have more affordable health care coverage than is otherwise available with an "age-rated" individual health insurance policy. Of course, this approach would be limited to the recently unemployed with prior employer-based insurance—a relatively small portion of the high-risk population—but for those individuals, especially those between the ages of 50 to 64, the COBRA extension could provide an affordable alternative to the individual health insurance market. AARP supports H.B. 5219 as an immediate step Connecticut can take to defray health insurance costs, particularly for older adults.

**H. B. 5235 AAC Evidence of Noncoverage of Health Insurance**

AARP supports H.B. 5235, which requires insurance companies to promptly notify customers in writing when a claim is denied based on the fact that the requested services is not a covered benefit under the individual's health care policy. The notice required by H.B. 5235 would include the relevant provisions of the insurance policy and inform consumers of their right to contact the Office of the Health Care Advocate for help appealing the denial of coverage. H.B. 5235 is modeled after a California law that requires insurance companies to notify consumers in writing that a claim has been denied and to instruct consumers about their rights to an appeal. AARP believes that H.B. 5235 would provide consumers with important information about their rights to an appeal and empower them to make informed choices about their health care coverage. We support the legislation and urge its support.

194
5235
5219

PAGE 10
LINE 10
SPOKE on #11 3

# State of Connecticut

OFFICE OF THE SPEAKER
LEGISLATIVE OFFICE BUILDING, ROOM 4100
HARTFORD, CONNECTICUT 06106-1591

**Testimony of Speaker of the House Christopher G. Donovan**
**To the Insurance and Real Estate Committee**
**in support of:**
**Senate Bill 194, *AAC Rate Approvals for Individual Health Insurance Policies*,**
**House Bill 5235, *AAC Evidence of Noncoverage of Health Insurance, and***
**House Bill 5219, *AA Extending State Continuation of Health Insurance Coverage***
February 25, 2010

Good afternoon Representative Fontana, Senator Crisco, and members of the Insurance and Real Estate Committee.

I appreciate the opportunity to express my strong support for **Senate Bill 194, *An Act Concerning Rate Approvals for Individual Health Insurance Policies***, a proposal which empowers consumers and holds insurance companies accountable for premium rate hikes. As you will recall, last summer Anthem Health Plans proposed a 32% rate increase on its individual health insurance policyholders. The proposed increase affected 56,000 Connecticut residents—many of whom are self-employed, work for small businesses that can't access affordable coverage, or are already suffering from unemployment.

In the past, insurance company requests for premium increases have gone into effect after 30 days. Currently there is no requirement for a public hearing or affirmative approval of these requests by the Insurance Department. When Anthem's most recent request sparked public outcry, the Insurance Department held a public hearing and heard from consumers, legislators, the state Healthcare Advocate, and the Attorney General.

Still, the Department approved a rate hike of up to 20% for 2010—costing residents thousands of additional dollars in insurance premiums. In addition, in December the non-partisan Office of Legislative Research released a report documenting the frequency of insurance company rate requests and Insurance Department rate approvals on individual policies in the last several years. Each of the eleven most recent rate increase requests on individual policies have been approved by the Insurance Department. Eight of these proposals have been in the double-digits and nine of the requests have been approved as filed, leading many consumers and state officials to question the level of scrutiny applied by the Department in examining whether the rates are "excessive" or "unfairly discriminatory" as is required by statute.

Shocking double-digit increases have been proposed in at least a dozen states in the past year, even as insurance companies report record-breaking profits. Several of these increases were highlighted by a report released last week by the U.S. Department of Health and Human Services entitled, *Insurance*

*Companies Prosper, Families Suffer: Our Broken Health Insurance System.* If we do not take action to rein in health insurance companies, provide more affordable options, and protect consumers from abusive insurance company practices, families and businesses will continue to be crushed by rising health care costs. Keeping health care costs affordable will save Connecticut jobs.

As we discuss important health insurance reform proposals in Connecticut today, President Obama is convening a bipartisan summit in Washington to facilitate an open discussion on how to make our health care system work better for all Americans. I was pleased to see that the new proposal released by the White House this week included a provision establishing a Health Insurance Rate Authority to bolster state rate review efforts and monitor insurance market behavior. SB 194 offers Connecticut the opportunity to be a leader in the fight the against anti-consumer and anti-small business tactics of the insurance companies.

Specifically, this legislation:

- Eliminates the Insurance Department's ability to allow rate hikes to take effect without a public hearing.
- Requires insurance companies to notify all policyholders of requests for rate increases, and the date, place, and time of the public hearing.
- Requires insurers to disclose documentation in support of rate increases for public scrutiny.
- Limits reasons for a rate increase, and the puts burden of proving that an increase is "reasonable" on the insurer.
- Empowers the Attorney General and the state Healthcare Advocate to intervene in rate cases and appeal rate decisions to the Superior Court.

I would also like to take this opportunity to express my strong support of two other measures being heard in this committee today, **House Bill 5235, *AAC Evidence of Noncoverage of Health Insurance,*** and **House Bill 5219, *AA Extending State Continuation of Health Insurance Coverage.***

HB 5235 requires insurance companies to notify consumers in writing that a claim has been denied, cite the relevant provision of the insurance policy, and refer the consumer to the Office of the Healthcare Advocate for assistance with an appeal. This bill addresses one of the most egregious abuses of insurers, incorrectly denying consumers the coverage they pay for with their premium dollars. This bill arose from the experience of a member of our legislative community, but consumers across out state are victimized by similar unfair practices. This proposal will give consumers the tools they need to fight inappropriate denials of coverage and get the health care they deserve.

At a time when so many Connecticut families are experiencing job loss, HB 5219 will provide them with the option of continuing their employer sponsored health coverage under COBRA for a total of 30 months after they are laid off. Under federal COBRA law, former employees who choose to temporarily stay on their employer's group policy pay 100% of the premium cost and may stay on the policy for up to 18 months. (Recent federal legislation assists laid off employees by subsidizing 65% of their premiums for up to 15 months.) HB 5219, would simply allow Connecticut residents to retain their COBRA benefits for an additional 12 months, without a subsidy. This will allow them to take advantage of group insurance rates, while they look for employment and replacement health coverage.

I would like to commend the Insurance Committee for pursuing these and other pieces of legislation that will protect consumers and promote transparency and accountability in the health insurance market.

I urge your support for these important proposals.

# JOINT
# STANDING
# COMMITTEE
# HEARINGS

## INSURANCE AND
## REAL ESTATE
## PART 4
## 1002 – 1329

**2010**

5235

Dr. M. Bhaya

Testimony of the

Connecticut ENT Society

Connecticut Urology Society

Connecticut Society of Eye Physicians

Connecticut Dermatology and Dermatologic Surgery Society

Connecticut Chapter of the American College of Surgeons

On H. B. No. 5235 An Act Concerning Evidence of Noncoverage of Health Insurance

Before the Insurance and Real Estate Committee

On

Before the Insurance and Real Estate Committee

On

February 25, 2010

Good Afternoon, Senator Crisco, Representative Fontana and other distinguished members of the Insurance and Real Estate Committee, my name is Dr. Mahesh Bhaya, and I am a board certified otolaryngologist practicing in Waterbury, CT. I am here as a representative to over 1400 physicians in the medical fields of Otolaryngology, Ophthalmology, Dermatology, General Surgery and Urology to support HB 5235, An Act Concerning Evidence of Noncoverage of Health Insurance.

First, I would like to thank this committee for considering a bill that will help improve delivery of healthcare for Connecticut residents. Our societies applaud any effort to improve the transparency, when claims are denied and SB5235 does exactly that. It will provide more information to the insured and to the provider as to why their claim has been denied. This will cut down on the frustration in patients when a claim is denied without any explanation. This bill will also help to standardize and regulate the response time for a denial of service. The insurance industry has enormous computing power at its disposal so it is hard to imagine that a rapid determination of coverage is not possible, especially considering that human lives and suffering are often on the line.

We agree with the Office of Healthcare Advocate (OHA) that this service should be extended to all denial notices, including those based on medical necessity. Finally, the requirement that patients who receive a denial also receive information on how to contact the Insurance Department and the Office of Healthcare Advocate for assistance on their denial is both welcome and needed. It would stand as a buttress supporting the weak and the infirm who should be concentrating their effort on their health and not on insurance forms and declarations.

In closing, we strongly support HB 5235 for the transparency and advocacy this bill seeks for Connecticut residents. Thank you

FTR
5235

*Quality is Our Bottom Line*

**Insurance Committee Public Hearing**
**Thursday, February 25, 2010**

**Connecticut Association of Health Plans**

**Testimony regarding**

**HB 5235 AAC Evidence of Noncoverage of Health Insurance.**

The Connecticut Association of Health Plans respectfully requests that the Insurance Committee take no action of HB 5235 AAC Evidence of Non Coverage of Health Insurance. This bill is incredibly burdensome from both an administrative and cost perspective and we would argue that our collective efforts are better directed at initiatives aimed at assessing denial data in a non-politicized and comprehensive manner so as to determine what, if any, new policy directives should be undertaken. The Committee has other proposals under consideration that we would welcome continuing a dialogue on, however, HB 5235 goes in the wrong direction at the wrong time and we respectfully ask for its rejection.

Thank you for your consideration.

Vicki Veltre

5235

5219

OFFICE OF THE
HEALTHCARE ADVOCATE
STATE OF CONNECTICUT

Page 20
Line 17

**Testimony of Kevin P. Lembo**
**Healthcare Advocate**

**Before the Insurance and Real Estate Committee**
**In support of HB 5235 and HB 5219**
**February 25, 2010**

Good afternoon, Representative Fontana, Senator Crisco, 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. The Office of the Healthcare Advocate (OHA) is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health 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 HB 5235, An Act Concerning Evidence of Noncoverage of Health Insurance. Specifically, this bill requires insurance companies to notify consumers in writing that a request for services has been denied; provide them with a denial notice that includes the relevant portion of the insurance policy on which the insurer based its denial; and, provide as part of the denial notice the name and contact information for the Office of the Healthcare Advocate for assistance with an appeal. The current text of this bill is limited to the denials of services on the basis that the services weren't specifically part of the contract. After discussion with the bill's sponsor, we strongly recommend including all denial notices in the scope of this bill, including those based on medical necessity.

OHA is the only state agency dedicated solely to consumer assistance with health insurance denials. Our office was established with the specific responsibility to walk with consumers through the process, and participate in appeals on their behalf. In 2009, OHA served over 2,600 consumers and realized savings of $6.7 million. This work was accomplished by 3 full-time, case work staff. In that same year, the state Insurance Department, with 5 full-time staff dedicated to health care casework reported 3,000 health cases, and $1.3 million in health care savings.

Vicki Veltre

No other agency does what we do, and no other agency can do what we do free from competing responsibilities. Listing both OHA and Insurance Department in the notices created by HB 5235 creates confusion for consumers, disparate outcomes for consumers, and potential redundancy. Since OHA is the office designed to handle such health insurance cases from beginning to end, including OHA on the denial notices will ensure the consumer receives the level of assistance contemplated by HB 5235.

OHA also supports HB 5219. HB 5219 extends the length of coverage under our mini-COBRA fill from eighteen to thirty months. The extension of our mini-COBRA will allow employees who have been laid off to keep their coverage for a longer period while searching for new employment. Under this bill Connecticut's mini-COBRA will allow people who are otherwise ineligible to receive federal COBRA or whose federal COBRA has terminated to maintain group coverage at a group rate for a longer period, thirty months, than previously permitted. In Connecticut, where jobs recovery is lagging far behind that of the rest of the country, the mini-COBRA extension will prevent most laid-off employees from losing their insurance coverage. Failure to pass HB 5219 will result in many laid off employees losing their group insurance and, at best, finding themselves in the individual market or, at worst, uninsurable.

Thank you for allowing me to testify today in support of HB 5235, with suggested changes, and HB 5219.

**S – 602**

# CONNECTICUT
# GENERAL ASSEMBLY
# SENATE

## PROCEEDINGS
## 2010

**VOL. 53**
**PART 5**
**1267 – 1608**

THE CHAIR:

Seeing no objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

Mr. President -- and the next two items to mark as go, first is calendar page 14, Calendar 418, House Bill 5235 from the Insurance and Real Estate Committee.

And second is calendar page 21, Calendar 138, Senate Bill 107 from the Commerce Committee.

THE CHAIR:

Thank you, sir.

Mr. Clerk.

THE CLERK:

Calendar page 14, Calendar 418, File 217, substitute for House Bill 5235, AN ACT REQUIRING THE PROVIDING OF CERTAIN INFORMATION UPON CERTAIN DENIALS OF HEALTH INSURANCE COVERAGE, Favorable Report of the Committee on Insurance.

THE CHAIR:

Senator Looney.

SENATOR LOONEY:

Yes, Mr. President. If we might stand at ease for just a moment.

THE CHAIR:

The Senate will stand at ease.

THE CHAIR:

The Senate will come back to order.

Senator Looney.

SENATOR LOONEY:

Yes, Mr. President. If we might proceed on that item.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Mr. President, my apologies to the Chair and members of the circle.

I move for acceptance of the Joint Committee's Favorable Report and passage of the bill.

THE CHAIR:

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

SENATOR CRISCO:

Yes, Mr. President, and members of the circle.

Unfortunately, in the past we've had reports of people being informed that they do not have coverage for a certain procedure, and then a couple days later being told that they do have coverage, and then

speaking on the phone to insurance company representatives that they don't have coverage.

So we had an unfortunate incident where an individual had a very serious procedure to schedule because of a major illness, and the person went through an extreme amount of -- of lack of knowledge whether or not they had coverage or did not have coverage.

This bill requires certain health insurers who deny coverage of a requested service because it is not medically necessary or a covered benefit to notify the insured of his or her ability to contact the Office of Healthcare Advocate if the -- if the insured believes he or she has been given erroneous information.

Insurers must provide the information to the insured with the appropriate contact. That is, it really creates more of a confirmation of what really the coverage is, Mr. President.

Thank you, sir.

THE CHAIR:

Remark further on House Bill 5235.

Senator Caligiuri.

SENATOR CALIGIURI:

Thank you, Mr. President.

Speaking very briefly in favor of the bill, it was a pleasure for me and other members of the Insurance Committee to support this bill, because as Senator Crisco pointed out, it's really designed to inform the insurance-buying public and consumers of the rights that they have and, frankly, the access that we as a state make available to them in terms of resources to whom and to which they can turn in the event that they're denied coverage.

We've created a system of safeguards and of protections for the insurance--buying public in the event that coverage is denied.

And I think one of the advantages of this bill is that we're helping to make consumers more aware of those resources which we have made available to them.

By making them aware of it, I think they're in a better position to avail themselves of those services and ultimately protect themselves from decisions that may have been wrongly made.

And for those reasons, I was happy to support the bill in the Insurance Committee and look forward to voting in favor of it this evening.

Thank you, Mr. President.

THE CHAIR:

Thank you, sir.

Will you remark further on House Bill 5235? Will you remark further on House Bill 5235?

If not, Mr. Clerk -- Senator Crisco, do you want to place this on the consent calendar?

SENATOR CRISCO:

Yes, Mr. President. I wasn't aware there was a consent calendar.

THE CHAIR:

We always do on special days like this.

SENATOR CRISCO:

I know, I know, but such a brief calendar. If there's no objection, I would request it be placed on the consent calendar.

THE CHAIR:

There's a motion by Senator Crisco to place this item on the consent calendar.

Seeing no objection, so ordered.

Mr. Clerk.

THE CLERK:

Calendar page 21, Calendar Number 138, File 189, substitute for Senate Bill 107, AN ACT ESTABLISHING A BRADLEY DEVELOPMENT ZONE, Favorable Report of Committees on Commerce and Export and

consent calendar.

THE CHAIR:

Mr. Clerk.

THE CLERK:

Roll call has been ordered in the Senate on the consent calendar. Will all senators please return to the chamber. Immediate roll call has been ordered in the Senate on the consent calendar. Will all senators please return to the chamber.

Mr. President, the Consent Calendar Number 1 begins on calendar page 12, Calendar 387, substitute for Senate Bill 212. Calendar page 13, Calendar 389, Senate Bill 430; calendar page 14, Calendar 418, substitute for House Bill 5235; and calendar page 19, Calendar Number 84, substitute for Senate Bill 118.

Mr. President, that completes those items placed on the 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 on the consent calendar. Will all senators please return to the chamber.

THE CHAIR:

The machine is open.

Will members please check the roll call board to see if their vote is properly recorded. If all senators have voted and all votes are properly recorded, the machine will be locked.

Would the Clerk please announce the tally.

THE CLERK:

Motion's on adoption, Consent Calendar Number 1.

| | |
|---|---|
| Total Number Voting | 35 |
| Those Voting Yea | 35 |
| Those Voting Nay | 0 |
| Those Absent, Not Voting | 1 |

THE CHAIR:

Calendar is adopted.

SENATOR LOONEY:

Mr. President.

THE CHAIR:

Senator Looney.

SENATOR LOONEY:

Thank you, Mr. President.

Mr. President, I believe the Clerk is in possession of Senate Agenda Number 3 for today's session.

THE CHAIR: