

Legislative History for Connecticut Act

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Bill Number: 351	
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2003

Transcripts from the Joint Standing Committee Public Hearing(s) and/or Senate and House of Representatives Proceedings

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S-479

CONNECTICUT
GEN. ASSEMBLY
SENATE

PROCEEDINGS
2003

VOL. 46
PART 5
1231-1576

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001439

Senate

Wednesday, April 30, 2003

will be locked. The Clerk please announce the tally.

THE CLERK:

Motion is on passage of S.B. 4.

Total number voting, 34; necessary for passage, 18.
Those voting "yea", 31; those voting "nay", 3. Those
absent and not voting, 2.

THE CHAIR:

The bill is passed.

THE CLERK:

Calendar 163, File 217, S.B. 351 An Act Concerning
Deficiencies In Insurance Claim Information. Favorable
Report of the Committee on Insurance. The Clerk is in
possession of two amendments.

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

Thank you, Madam President. Madam President, I
move for acceptance of the Joint Committee's Favorable
Report and passage of the bill.

THE CHAIR:

The question is on passage. Will you remark?

SEN. CRISCO:

Madam President, I believe the Clerk has an
amendment, LC05444.

THE CLERK:

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001440

Senate

Wednesday, April 30, 2003

LC05444 which will be designated Senate Amendment
Schedule "A". It is offered by Senator Crisco of the
17th District.

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

Thank you, Madam President. Madam President, I
move for adoption of the amendment and be given
permission to summarize.

THE CHAIR:

The question is on adoption. Please proceed.

SEN. CRISCO:

Thank you, Madam President. Madam President, the
amendment clarifies that the criteria established under
the bill, criteria to begin what's known as the
processing of a claim, and thereby starts the clock
ticking for the purpose of prompt payment statutes.

This is to require that it gives insurers only 30
days in which to request any additional information from
providers. And the amendment also clarifies that the
criteria do not constitute the definition of a clean
claim.

Basically, Madam President, this allows the
insurance company to get the information and then clock
starts ticking which imposes the requirement that there

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001441

Senate

Wednesday, April 30, 2003

be a response in so many days.

THE CHAIR:

The question is on adoption of Senate Amendment "A". Will you remark further? If not, I will try your minds. All those in favor indicate by saying "aye".

ASSEMBLY:

Aye.

THE CHAIR:

Opposed, "nay"? The ayes have it. The amendment is adopted. Will you remark further on the bill as amended?

SEN. CRISCO:

Yes, Madam President.

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

If there is no objection, I request that it be put on the Consent Calendar.

THE CHAIR:

Motion is to refer this item to the Consent Calendar. Without objection, so ordered.

THE CLERK:

Calendar Page 7, Calendar 282, File 244 and 426, Substitute for H.B. 6584 An Act Concerning Changes In Ownership Of Retail Liquor Permit Premises, as amended

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001524

Senate

Wednesday, April 30, 2003

the Consent Calendar. And before I open the machine, would you call those items on the Consent Calendar.

THE CLERK:

An immediate roll call has been ordered in the Senate on the Consent Calendar. Will all Senators please return to the Chamber.

An immediate roll call has been ordered in the Senate on the Consent Calendar. Will all Senators please return to the Chamber.

Madam President, the First Consent Calendar begins on Calendar Page 1, Calendar 77, S.B. 333.

Calendar Page 4, Calendar 142, Substitute for S.B. 1015.

Calendar Page 5, Calendar 163, S.B. 351.

Calendar Page 8, Calendar 287, H.B. 6199.

Calendar 294, H.B. 6359.

Calendar Page 12, Calendar 332, Substitute for S.B. 941.

Calendar Page 13, Calendar 341, Substitute for H.B.

6376.

Calendar Page 19, Calendar 141, Substitute for S.B.

922.

Madam President, that completes those items previously placed on the First Consent Calendar.

THE CHAIR:

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001525

Senate

Wednesday, April 30, 2003

Would you once again call the, announce a roll call vote. The machine will be opened.

THE CLERK:

An immediate roll call has been ordered in the Senate on the Consent Calendar. Will all Senators please return to the Chamber.

An immediate roll call has been ordered in the Senate on the Consent Calendar. Will all Senators please return to the Chamber.

THE CHAIR:

Have all members voted? If all members have voted, the machine will be locked. The Clerk please announce the tally.

THE CLERK:

Motion is on adoption of Consent Calendar No. 1.
Total number voting, 31; necessary for adoption, 16. Those voting "yea", 31; those voting "nay", 0. Those absent and not voting, 5.

THE CHAIR:

The Consent Calendar is adopted. Senator DeFronzo.
SEN. DEFRONZO:

Madam President, I just wanted to indicate that my electric vote did not register. It doesn't seem to, it wasn't functioning at the time. Just for the record.

THE CHAIR:

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001526

Senate

Wednesday, April 30, 2003

The Journal will so note. Senator Looney.

SEN. LOONEY:

Thank you, Madam President. Madam President, given that malfunction, I would move to reconsider the previous vote on the Consent Calendar. I was on the prevailing side.

THE CHAIR:

I was going to ask if you were sure. Motion is for reconsideration of the Consent Calendar. Without objection, we will reconsider that. Mr. Clerk, would you once again announce a roll call vote on the Consent Calendar.

We would ask the members' indulgence of the score board, if you want to call it that. It actually shows Consent Calendar 2. It is Consent Calendar 1. We will not recall those items. Mr. Clerk, would you announce a roll call vote. The machine will be opened.

THE CLERK:

An immediate roll call has been ordered in the Senate on the First Consent Calendar. Will all Senators please return to the Chamber.

An immediate roll call has been ordered in the Senate on the Consent Calendar. Will all Senators please return to the Chamber.

THE CHAIR:

pat

163

001527

Senate

Wednesday, April 30, 2003

Have all members voted? If all members have voted, the machine will be locked. The Clerk please announce the tally.

THE CLERK:

The motion is on adoption of Consent Calendar No. 1.

Total number voting, 32; necessary for adoption, 176. Those voting "yea", 32; those voting "nay", 0. Those absent and not voting, 4.

THE CHAIR:

The Consent Calendar is adopted.

Senator Looney.

SEN. LOONEY:

Thank you, Madam President. At this time, I would like to mark the next three items to be considered. They are three bills from the Committee on Government Administration and Elections, Calendar 130, Calendar 157 and Calendar 189.

THE CLERK:

Calendar Page 18, Calendar 130, File 165, S.B. 343
An Act Designating Juneteenth International Day,
Independence Day. Favorable Report of the Committees on
Government Administration and Elections and Education.

THE CHAIR:

Senator DeFronzo.

H-894

CONNECTICUT
GEN. ASSEMBLY
HOUSE

PROCEEDINGS
2003

VOL. 46
PART 9
2685-3053

gmh

House of Representatives

Tuesday, May 13, 2003

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.

DEPUTY SPEAKER FRITZ:

Have all the members voted? Have all the members voted? Please check the machine to be sure your vote is accurately cast. If so, the machine will be locked and the Clerk will take the tally.

The Clerk will announce the tally.

CLERK:

H.B. 6391

Total Number Voting	140
Necessary for Passage	71
Those voting Yea	140
Those voting Nay	0
Those absent and not Voting	10

DEPUTY SPEAKER FRITZ:

The bill is passed.

Will the Clerk please call Calendar number 413.

CLERK:

On page 11, Calendar 413, S.B. 351, AN ACT
CONCERNING DEFICIENCIES IN INSURANCE CLAIM INFORMATION.
Favorable Report of the Committee on Insurance and Real
Estate.

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93 002723

House of Representatives

Tuesday, May 13, 2003

DEPUTY SPEAKER FRITZ:

Representative Orefice.

REP. OREFICE: (37TH)

Thank you, Madam Speaker. I move we accept the Joint Committee's Favorable Report and passage in concurrence with the Senate.

DEPUTY SPEAKER FRITZ:

Thank you, sir. The question is on acceptance and passage in concurrence with the Senate.

Will you remark further, sir?

REP. OREFICE: (37TH)

Yes, Madam Speaker. This bill will clarify the minimum information needed for health care providers to submit a complete claim for processing. For some background, in 1998, this body passed a prompt legislation payment providing that payment be made within 45 days of a claim. This bill attempts to clarify what makes a clean claim for filing purposes.

Madam Speaker, the Clerk has LCO 5444. May he call and may I have permission to summarize?

DEPUTY SPEAKER FRITZ:

Will the Clerk please call LCO number 5444, previously designated Senate Amendment "A".

CLERK:

LCO number 5444, Senate "A" offered by Senator

gmh

House of Representatives

Tuesday, May 13, 2003

Crisco.

DEPUTY SPEAKER FRITZ:

Representative Orefice.

REP. OREFICE: (37TH)

Thank you, Madam Speaker. This is a language clarification that was adopted by the Senate. It helps clarify the purpose of the bill and I urge adoption.

DEPUTY SPEAKER FRITZ:

The question is on adoption of the amendment. Will you remark further on the amendment before us? If not, let me try your minds.

All those in favor, please signify by saying aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER FRITZ:

Those opposed, nay. The ayes have it, the amendment is adopted.

Will you remark further on the bill, as amended?
Will you remark further on the bill, as amended? If not, will staff and guests please come to the Well of the House and the machine will be opened.

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.

gmh

House of Representatives

Tuesday, May 13, 2003

DEPUTY SPEAKER FRITZ:

Have all the members voted? Have all the members voted? Please check the board to be sure your vote is accurately cast. If so, the machine will be locked and the Clerk will take the tally.

The Clerk will announce the tally.

CLERK:

S.B. 351, as amended by Senate Amendment Schedule "A" in concurrence with the Senate

Total Number Voting	140
Necessary for Passage	71
Those voting Yea	140
Those voting Nay	0
Those absent and not Voting	10

DEPUTY SPEAKER FRITZ:

The bill is passed, in concurrence with the Senate.

Will the Clerk please call Calendar number 416.

CLERK:

On page 12, Calendar 416, Substitute for S.B. 1015, AN ACT REQUIRING NOTICE TO PERSONAL RISK POLICYHOLDERS AND CLAIMANTS REGARDING SERVICES PROVIDED BY THE INSURANCE DEPARTMENT. Favorable Report of the Committee on Insurance and Real Estate.

DEPUTY SPEAKER FRITZ:

Representative Megna.

JOINT
STANDING
COMMITTEE
HEARINGS

INSURANCE
AND
REAL
ESTATE
PART 3
709-1095

2003

SEN. CRISCO: Thank you sir, any other questions? Thank you very much.

JIM PASCARELLA: Very nice to see the PIA and the AIC testify in support of or opposed to the same bill.

SEN. CRISCO: Anybody else to testify on this bill? Thank you very much, proceeding to bill number eight, SB351, Dr. Parke followed by Ms. Osborn.

DR. DAVID PARKE: Sen. Crisco, Rep. Orefice and members of the Insurance and Real Estate Committee.

My name is David Parke, Chairman of the Connecticut State Medical Society Committee on Legislation.

Thank you for the opportunity to provide comments today regarding SB351, AN ACT CONCERNING DEFICIENCIES IN INSURANCE CLAIM INFORMATION.

And SB1088, AN ACT CONCERNING MEDICAL MALPRACTICE INSURANCE RATES.

The Connecticut State Medical Society supports SB351. This General Assembly has passed legislation requiring health insurance companies to compensate positions for their services in a timely manner or face the possibility of penalties for failing to do so.

Insurers are granted additional time to pay claims when more information is necessary guarding the services provided.

However, current statute that lacks -- the current statute lacks in adequate definition as to a "clean claim." It has allowed insurers to abuse the law obtaining additional time by returning claims for information they deem to be missing. That is irrelevant or not necessary to identify the physician, patient insured, or service provided.

This legislation will clearly define the information needed, in order for a claim to be paid in a timely manner.

When physicians bill for services, they use

standard forms, most often HCFA 1500. Utilizing standard codes known as CPT-3 codes. As you can see from the proposed legislation, these forms require the submission of great deal of information.

I can think of no information not contained in these forms that has any relevance to the service provided or that would have any impact on appropriate reimbursement.

Yet, we are continually contacted at the Connecticut State Medical Society by physicians who have claims denied or delayed when all of this information has been provided.

This is unfair, and abuses the intention of this General Assembly's timely payment laws. We ask your support of this legislation.

Regarding SB1088, AN ACT CONCERNING MEDICAL MALPRACTICE INSURANCE RATES. During the 2002 session of the General Assembly, CSMS sought legislation that would have required a study of the pending crisis of the availability and affordability of medical liability insurance.

That legislation was unsuccessful. Unfortunately, the time to undertake such a study has passed. Already, the lack of availability and affordability of medical liability insurance in the State is forcing and in many cases has forced doctors to make agonizing decisions about their ability to remain in the professions they love and have devoted their lives to.

We know that the crisis is here. Last Monday, the American Medical Association Classified Connecticut as one of 18 states with a full-blown medical liability insurance crisis.

We also know that the issue has been studied by many organizations, most notably the Department of Health and Human Services and most recently by the Governor's Select Task Force on Healthcare Professionals Liability Insurance in Florida.

The findings consistently show the crisis is less acute in states that have changed their litigation systems with reforms anchored by a \$250,000 cap on non-economic damages; findings support by the Rand Corporation, Congress' Office of Technology Assessment, and the American Academy of Actuaries and others.

The members of the Connecticut State Medical Society cannot allow inaction during this session. We cannot operate under a crisis that is having a direct and significant impact on access to health care in Connecticut. Thank you.

SEN. CRISCO: Thank you Dr. Parke, any questions? Yes, Rep. Altobello.

REP. ALTOBELLO: Thank you, good afternoon Doctor. Do you have any knowledge concerning President Bush's proposal on the Federal side and whether that's moving forward or not?

DR. PARKE: There is supposed to be some action taken in Committee this week in Washington.

If we wait for Washington to take effect we may be waiting for a long time so I think that the time to act for Connecticut is right now.

REP. ALTOBELLO: So you're not handicapping that bill in D.C. presently?

DR. PARKE: No.

REP. ALTOBELLO: Thank you.

SEN. CRISCO: thank you, you know we made an exception, we ask people only to testify on the bill that is before them for this particular category.

But thank you, Dr. Parke and Rep. Altobello, I believe there will be a house vote tomorrow or today in regards to malpractice in Congress. Thank y-u ve-y mu_h. .s. .sb..n.

DEB OSBORN: Good afternoon, Sen. Crisco, Rep. Crifice and other distinguished members of the Insurance

SB351

Committee.

I am here today as the Executive Director of The Connecticut Dermatology and Dermatological Surgery Society and as Executive Director of the Connecticut Society of Eye Physicians. I am here today to speak in favor of SB351.

It is never the intent of the legislature to pass a bill and then have it ignored. But that is precisely what has happened with Connecticut's Prompt Payment Law.

In 1998, the Connecticut Legislature passed legislation to address the problem of delayed payments by the HMOs to healthcare providers.

This legislation required HMOs to pay physicians and other healthcare providers within 45 days of receiving a medical claim.

Unfortunately, the legislation was created in such a way that it allowed the HMOs to avoid their 45-day payment requirement by saying that the provider did not submit adequate information upon submission.

Without a definition of "clean claim" in the statute, carriers were allowed to determine what they felt constitutes a "clean claim."

By 2000, each insurance carrier was using this loophole as a delay tactic in paying claims. On August 23 of 2000, the Insurance Commissioner announced that new progress on the prompt payment law was made and the following bulletin, HC-56 was crafted to provide consistency in what constituted a "clean claim" for healthcare providers.

The intent of this Bulletin was to give relief to the physicians who still were not being paid promptly. Here it is 2003 and guess what? Physicians are still waiting 60, 90, 120 days for payment.

SB351 simply codifies this same definition and forces all parties to acknowledge what truly is required to receive settlement on a healthcare

claim.

I will leave you by saying that in my position, I have seen thousands, tens of thousands of claims that have not been paid promptly.

On the explanation of benefits, they give an explanation of why this claim has not been paid and they'll say we need further documentation.

This would avoid those responses by carriers, thank you.

SEN. CRISCO: Thank you Ms. Osborn, are there any questions? Chairman Orefice.

REP. OREFICE: the items listed in the bill, I mean these were essentially agreed to under the prior legislation, this is an attempt to -- I mean these had all been reached in an agreement with the carriers, item T1 through --

DEB OSBORN: Absolutely. I brought a copy of the bulletin and I will leave them at the desk.

This is the exact Bulletin that the Insurance Commissioner agreed upon by the carriers and the providers that if they filled out these fields it would constitute a "clean claim."

And I brought copies but it was in red and it didn't copy so well. But if you really look closely, you'll get it.

REP. OREFICE: And the last questions was on -- is their some carriers that are better than others or some that are notorious for abusing the system?

DEB OSBORN: Absolutely.

REP. OREFICE: I wont ask you for the names but so in other words --

DEB OSBORN: Are you sure?

SEN. CRISCO: She has them.

DEB OSBORN: Yeah there is. But it would help the physicians and other healthcare providers get payment on a timely basis.

REP. OREFICE: Thank you.

SEN. CRISCO: Thank you Debbie. And if you want to send up that information later on, you could if it's more clear. Thank you.

DEB OSBORN: Okay, I'll look for a better copy.

SEN. CRISCO: Dr. Thornquist.

DR. STEVE THORNQUIST: Thank you Sen. Crisco, Rep. Orefice and other members of the Committee.

I actually have her original red copy of you'd like that one, it's a little easier to read although, I did remind her that the federal government when it doesn't want documents copied puts them on red paper, so.

In any event, I am Steve Thornquist; I am a Board Certified Ophthalmologist. Practicing in Trumbull, Connecticut and I'm here as an officer of the Connecticut Society of Eye Physicians. An organization representing over 90% of the ophthalmologists practicing in Connecticut.

And were here to support this SB351. First, I'd like to commend this Committee for raising a bill that will help physicians, health care providers, and patients achieve prompt payment and reasonable access to health care through that.

It is frustrating; I just opened my practice in May down in Trumbull after being with a very large group which took care of all this stuff for me. I didn't have to think about it too much. Sometimes I wonder if that wasn't a better deal. It's frustrating for me. I have to pay my rent on time; I have to pay my oil bills on time. I don't even want to tell you what happens if I don't pay my credit card bills on time.

But I do have a 20% APR on one of my cards now.

The fact of the matter is that all my bills get paid on time because they have to be. I do the work in good faith, I see the patient I do what needs to be done, I send it off, I get all the information, I do what they ask me to fill out on the form. And it comes back because I need a different modifier cause they decided this month to change the way the modifier works.

Or they want the records because they do. Or I mean there's a lot of ways that suddenly the claim is no longer clean even though I've filled out all of these little blanks on here as the State Commissioner suggested.

And it is very frustrating for claims for me to go 60 to 120 days unpaid when I still have the same cash flow that every other business has.

And its -- because this was never codified under statute there's not much of a weapon to go back after them with.

And that loophole has allowed the HMOs to stop the clocks on timely payment. They simply tell me that they need more information or they want it presented in a different way and off we go again.

And many times the request is totally frivolous, has nothing to do with patient care or review of the care.

It's an unfair trade practice. It puts a tremendous burden on me. I have my office manager working on this; I have a billing person specifically that I contract to do with to do this.

And every year I see a lot of my colleagues getting frustrated more and more by the volume of this stuff that they have to deal with.

It's becoming increasingly more difficult and more costly to practice medicine, we may not be able to fix all the problems ailing the health care system today, but by passing this SB351 at least, the carriers will be forced to recognize what the Insurance Commissioner has already determined to be a fair practice.

The legislation that this body passed in 1998, regarding prompt payments is being flagrantly disregarded. And this gives us a chance to try to fix it. Thank you very much, I'll be happy to answer any questions.

SEN. CRISCO: Thank you Doctor, any questions. Thank you very much; I'm sorry, Rep. Nardello.

REP. NARDELLO: Thank you for being here today. I just want to follow up on something Debbie said that comes through in your testimony also. Is there certain companies that seem to be repeat offenders in this area?

DR. THORNQUIST: They all have different techniques and many of them are repeat offenders. I mean I don't -- is it okay to mention names? Health net in particular is one, they also have a fun job, -- they have a penchant for recoding what you send in. (Inaudible) surgery, it's a different surgery.

ConnetiCare has done this although they have gotten a little better about it. VSP does this to me a lot too.

REP. NARDELLO: The reason I ask this is if it seems to be a flagrant violation that seems to be coming through under one company, I believe they'd be subject to Unfair Trade Practices and I would ask why that has not been pursued.

DR. THORNQUIST: To be honest, that hasn't occurred to me. I would have to talk to the Society about doing that and about how -- what the legal ramifications of a Society trying to bring that kind of a practice suit would be.

Certainly for me to take the effort, the money, the time, the legal costs and everything to try to pursue that --

REP. NARDELLO: I wouldn't expect you to do it individually. The reason I say that also is because as a legislature, we put things into place, and you're right we like to see them enforced.

We don't put them in place so they'll be ignored. So if they're not being enforced than I really think that we need to send a message that this is not acceptable.

Now this is one way to do it through the bill. But even if we put this in a bill, which I'm supportive of doing, it doesn't mean again that there still going to do it.

We still have to get to the issue of enforcement. And I think that's an issue that needs to be addressed by your assistance and again looking into the area of Unfair Trade Practice because it may be one of the key areas to remedy this.

DR. THORNQUIST: I appreciate the suggestion, thank you.

SEN. CRISCO: Any more question, thank you very much Doctor. Christine.

CHRISTINE CAPPIELLO: Good afternoon, Sen. Crisco, Rep. Orefice and members of the Committee.

For the record, my name is Christine Cappiello and I am the Director of Government Relations for Anthem Blue Cross Blue Shield.

And I'm here today to speak to you about SB351, AN ACT CONCERNING DEFICIENCIES IN INSURANCE CLAIM INFORMATION.

We are in strong opposition to the bill because it essentially says that a claim only needs these fields to be considered a "clean claim" and therefore ready for processing.

If we need more information other than these fields, such as medical records and we don't receive those in the 45 day time period from the provider that we request from them, we would be subject to paying interest for something that is not in our control.

We need this information in order to properly

process a claim and ensure that our members are receiving the quality of care they deserve.

In the summer of 2000, the Insurance Commissioner issued a bulletin after sitting down with the Hospital Association, the Medical Society and the health plan industries. And what was agreed to in that Bulletin and I have a copy of the Bulletin also, is what is necessary for processing to start processing a claim? It does not define a "clean claim." In fact, it says this Bulletin is intended to define the minimum criteria for the acceptance of a claim.

It does not guarantee payment. The best way to ensure proper payment is to file a fully completed claim in accordance to the insurer's practices and procedures.

The criteria suggested by the members would not define what constitutes a "clean claim" or a claim containing all the information for payment by the insurer.

I think that's a very important distinction for what has been said. I also would like to remind the Committee that HIPPA which is due to come on line in October of this year, has a set of transaction codes which will come on as part of there administrative simplification which brings uniformity to the healthcare industry.

And payment for processing with providers. HIPPA - - with these transactions codes, they may change in going out in years -- going forward. This bill wouldn't allow us to comply with that HIPPA -- with those HIPPA code sets as they change.

So I think that's a very important distinction. I think that it's very important to note that we want the claims to be paid quickly and on time too. And that's why we sat down, and that's why we came up with the lists of fields in order to get the claim -- in order to get the claim in the door and start processing it.

And we have time restrictions we have only 30 days

in which to send back to the provider what's needed. In order to complete the claim. And we pay interest if we don't. So I think that those are very important distinctions that I set out. And we'll take any questions you might have.

SEN. CRISCO: Thank you any questions? Yes, Chairman Orefice.

REP. OREFICE: Its been testified that this was in 98 we agreed or there was an agreement -- and it was, if not put in statute -- a Bulleting that these would be the things that are necessary to start a claim. Your testimony is that there may be other things?

CHRISTINE CAPPIELLO: Oh yah, like medical records.

REP. OREFICE: Now can we -- would you be willing to suggest the things that are missing from this list to make -- is there a way to get a clean claim list? I mean if we could add whatever you need to add.

CHRISTINE CAPPIELLO: I think the problem is when we sat -- cause that was one of the things when we sat down as a group that we tried to come up with.

And what we found was that in different situations you need different things. So that s why we set the number of fields that were really the basics. Things like your name, your group number, whether you have insurance, the Doctors name. Very basic things.

And beyond that the kind of diagnosis codes or needing medical records. Those things vary depending on a specialty, depending on whether it's a hospital, depending on whether it's a provider.

So we really struggled with that and that's why we came up with a list of -- in order to get it in and start processing it.

But that's also, why they put the time frames around it too. Which is that we've only got 30 days to get back to that provider and say okay we

need X Y and Z. Because of, you know because of the claim that's come in or the type of code that it is or the type of procedure. We need X,Y and Z.

So that we do get it back to them in a timely manner.

REP. OREFICE: So if you could figure out what X, Y and Z was we could add them to this list then we would avoid a lot of -- so maybe we could think about how we do X, Y and Z and put them on the list and then everybody would be happy.

CHRISTINE CAPPIELLO: Yeah I think it's just -- the problem as I said that we came about when we all sat down, as a group is that as you get into that area it depends. It depends -- I mean it kind of depends and then it becomes a situation where, are you asking for a lot of information and they're delayed in even getting it started. I mean the whole idea was get it in the door.

REP. OREFICE: Thank you.

SEN. CRISCO: Thank you, Rep. Fontana.

REP. FONTANA: Thank you Mr. Chairman. Good afternoon Christine.

CHRISTINE CAPPIELLO: Good afternoon.

REP. FONTANA: Feels like deja vous, all over again.

CHRISTINE CAPPIELLO: I don't like this room, it's too big.

REP. FONTANA: I didn't mean that I meant both you and I have been involved this process going back to 98. So we have looked into this issue over and over again.

And my comment is that there seems to be a disconnect that continues here. In your testimony, you state that you're unaware of any problems and this is something that seems to be working well.

And then we receive testimony which says there's a

big problem and it's not working well. And there's disconnect.

CHRISTINE CAPPIELLO: Right.

REP. FONTANA: Now I appreciate that quite often people mention that, your particular company is not one, but there seems to be a problem out there and I guess what I would ask you is, those who support this bill to my mind say, there's an incentive for the HMOs and insurance companies to delay payment.

What I don't hear from the insurance companies and HMOs and managed care organizations is what incentive Doctors have not to provide clean claims. I mean they want to get paid and so I'm not clear why on earth a Doctor wouldn't give you a clean claim.

I mean, maybe you can just give me a sort of response or thought on that.

CHRISTINE CAPPIELLO: I think it depends. I mean the information also has to be accurate. I think it depends, I think that most Doctors do complete all the information necessary.

But in some instances, you have new office staff that maybe aren't used to the software. Or you have typically sometimes with hospitals things are happening very quickly and Doctors when there filling out things don't fill it out completely in order for the person whose inputting the claims to send off to us, have all the information. You'd be surprised sometimes the things that -- you would think a complete claim would come in.

REP. FONTANA: So in your perspective it's a matter of accuracy more so than a complete list.

CHRISTINE CAPPIELLO: It's sometimes accuracy and it's sometimes completeness. You would be surprised; we get claims that don't even have member's names on them.

So I think you're absolutely right, and I don't see that's the majority by any means.

REP. OREFICE: Right, but it happens and for whatever reason, I don't know whether it's and may be its --

REP. FONTANA: Well getting back to what Chairman Orefice said it seems to me accuracy is one thing that its hard for us to -- I mean we cant legislate accuracy --

CHRISTINE CAPPIELLO: Right.

REP. FONTANA: But to the extent that he was alluding to the completeness issue, it seems to be completeness should be an objective.

CHRISTINE CAPPIELLO: Right.

REP. FONTANA: -- an objective standard so, to the extent that there's a way to work with your -- I'd say brethren, but the other organizations that you are in concert with, on various issues that, we can at least get the completeness issued solved.

I mean I think that we really need to make progress on this and I'm sure we said that three years ago and five years ago, but we're really, really running out of time here. Thank you, thank you Mr. Chairman.

SEN. CRISCO: Thank you, Rep. Nardello.

REP. NARDELLO: Thanks Christine, I have a question. In terms of you said you might ask for medical history, would you be likely to ask for medical history if say it's an office visit or if it's an individual physician's office. When is the likelihood that you would ask for medical history?

CHRISTINE CAPPIELLO: I think that in that instance it would be very rare.

We're talking about situations where it may be a more complicated or complex situation. When a procedure is done, that's when it really -- that's when we get into it, not for a -- very rarely for an office visit.

REP. NARDELLO: The reason I ask that is cause maybe we can make a distinction. If you need additional information under certain settings then you need to look at that.

But I think the issue here is in the individual physician's office. That's where the problem is, those are the people that are going to testify, those are the people -- so therefore maybe when we do this we make a distinction that these things apply for individual physicians office claims.

When we get the more extensive claims then you retain the right to be able to request additional information. And that might be one way to solve this problem cause we've certainly been trying to do it for a very long period of time.

So could you address that and take -- and come back to me as to whether that might be a possibility of a way to address this.

CHRISTINE CAPPIELLO: Sure.

REP. NARDELLO: Because as I look at the list the bill is certainly a lot of information required.

CHRISTINE CAPPIELLO: Oh yeah.

REP. NARDELLO: It's not as if they're you know, there not completing the form. So I think it then becomes an issue of how we apply this and maybe there's a way to get around this.

CHRISTINE CAPPIELLO: Sure, I can take that back.

REP. NARDELLO: If you would, I would appreciate that.

CHRISTINE CAPPIELLO: Yep and let the Committee know.

SEN. CRISCO: Thank you any other questions? Thank you very much, Susan.

CHRISTINE CAPPIELLO: Thank you.

SUSAN HALPIN: Good afternoon, Sen. Crisco, Rep. Orefice and members of the Insurance and Real

SB 351

Estate Committee.

For the record, I'm Susan Halpin and I'm here before you today representing the Connecticut Association of Health Plans in opposition to SB351, AN ACT CONCERNING DEFICIENCIES IN INSURANCE CLAIM INFORMATION.

I'd like to associate my remarks with Christine Cappiellos who appeared before me.

We too participated in the organized effort under the direction of the Department of Insurance in the summer of 2000 along with the Connecticut State Medical Society, the Connecticut Hospital Association and other provider groups.

To address issues that arose as a result of the implementation of the prompt pay laws. As you probably would recall there were two separate prompt pay laws that were enacted.

The first was payment within 45 days of 15 percent interest.

The second was in the case of deficient information health plans were required to notify the provider within 30 days of what information was deficient and that upon receipt of that information, pay within 30 days or be subject to the 15% interest penalty again.

Upon implementation of these acts, there were questions that arose on behalf of the health insurers and the providers as to what triggered that 30-day clock.

Some claims came in, in such a deficient manner as Christine alluded to, its not the vast majority but there are claims that come in that don't have a name or an ID number and for those purposes those claims get kicked out and aren't registered as a claim.

So what constituted the trigger for that 30-day clock? The process that we under went with the Department of Insurance and the Connecticut State

Medical Society and the Hospital Association was designed to come up with the minimum set of criteria to constitute a claim so that you could determine when the trigger would start for the 30 day clock.

In working with those organizations the attached Bulletin which is attaché to my testimony was developed. Now while the bill before you nearly mirrors the claim Bulletin by DOI it differs in one critical regard, by virtue of the language in the bill it essentially says that these are a set of criteria constitute a clean claim.

And that's very different than saying that these set of criteria constitute a claim. So in saying that there was a loophole that plans were you know going through in order to avoid paying claims or void playing clean claims is not accurate.

This was designed to define what a claim was. The one thing I would say is ironic should this legislation pass if insurers are prevented from asking for additional information to support the claim that's before them. You may end up in a situation where more claims are denied upon their initial submittal rather than on -- rather than information being requested and then paid because the insurer would be required to make a decision based on the information that was before them.

In terms of I think Rep. Nardellos question earlier of you know in what case may you need more information. And medical records is the big one, there's no questions about that but say it's in a dermatologists office. Say there was a procedure performed, I can't name one, but you know many policies may exclude cosmetic benefits.

If there's medical records indicate that it was not cosmetic and therefore covered by the insurers plan you would need that medical -- that supporting documentation to make that determination whether it was a covered benefit under the policy.

So I would say again that we very much oppose this legislation. It is very different than the DOI

bulletin, very different from the intent.

In fact if you have the bulletin in front of you paragraph three, specifically states that the criteria that is suggested by the members would not define, not is in all capital letters, what constitutes a clean claim.

So we would urge your rejection and I thank you for your consideration.

SEN. CRISCO: Thank you Susan, are there any questions?
Yes Rep. Nardello.

REP. NARDELLO: I just need to follow up with you as well Susan.

I guess the issue here is when you cite the dermatologist's example; I don't think that happens very often. It may happen very infrequently and I think that we can work around that. I still say that if you want to work language that says that you're allowed to get medical records, which you should be allowed to get medical records, I don't think anybody is going to deny that including the physician.

But in the broad instance of places, you don't need the medical records so again I would ask you to go back to your members and see if there's a way that we can work this out in a way that allows you to obtain the ability to get medical records.

And that addresses the issue at hand which is inability to get paid for the claim in what they consider a prompt period of time.

SUSAN HALPIN: We're always happy to go back and work with our members. The thing I would say is I think its difficult to pinpoint exactly what information you would need to support a claim and I think as Christine alluded to before me when you have those strict parameters around the time frames in which we can request the information and then upon which we must act upon the information.

I think that language is designed to work with

those. If there are cases where that's not happening obviously, we should look into that and investigate and see why it's not happening.

But there are penalties in place, should someone be abusing that system that should work to avoid that in the future.

And again, I'd be happy to work with --

REP. NARDELLO: I believe we can solve this. I believe that if you put your heads together this can be solved. So all I'm asking you to do is take these thoughts into consideration and we need to find a way to solve them.

SEN. CRISCO: Thank you both very much. Michael Hampton.

MIKE HAMPTON: Thank you Chairman Orefice and Crisco, for the opportunity to be here to speak on SB351.

For the record, my name is Mike Hampton. I'm with Golden Rule Insurance. Golden Rule insures approximately 27,000 people here in the individual market in Connecticut.

Golden Rule has long had strict standards on time frames for processing of claims. Indeed in many ways they're stricter than the current standards here in Connecticut.

And for two very important reasons. For one our insured want us to protect them financially. Late payment of claims jeopardizes their financial future by risking them being sent to collection agencies by physicians not receiving timely payments.

And secondly, our agents don't want to have to hassle with getting their claims paid because they're having to constantly call Doctors and providers and insurance companies. Get all the stuff taken care of.

As we've already heard they're really two categories of information that carriers often

require in order to complete a processing of claims.

The first is of course the information on the claim form.

The second is additional information not available on the claim form.

This bill fails to recognize the second category and does not include all the really needed fields that are currently on the claim form as well.

We need medical records and information from other insurers to determine how to coordinate benefits, determine medical necessity, determine whether there is fraud or material misstatement, evaluate whether something is a preexisting condition and other reasonable requirements related to contract provisions.

This bill would greatly hamper our efforts to obtain this information would ultimately lead to either us denying more claims due to lack of information or paying unjustified claims.

Let me also speak on the issue of trying to address all the issues as far as trying to define what a "clean claim" is.

I worked in Maryland on the clean claim task force there and what we found -- we ended up drafting basically about a 40 page regulation to try to address all the potential issues as far as when we may need additional medical information and things like that.

I think if this Committee believes that we need to move forward on this I think the best way maybe to is look to going through a regulations avenue.

Because I think there are just too many angles and too many -- depending upon what kind of carrier you are, HMOs may have certain requirements where as indemnity and PPO carriers like us will have others.

So I think we need to be careful and I think whatever we do needs to be deliberate.

I thank you for the opportunity and I would be happy to answer any questions.

SEN. CRISCO: Thank you Mike for the suggestion, any questions? Thank you very much. No one else to testify on bill number eight, proceed to bill number 10, SB1088, Chris Bernard.

CHRIS BERNARD: Good afternoon, Sen. Crisco, Rep. Orefice and members of the Committee.

My name is Chris Bernard and I am President of the Connecticut Trial Lawyers Association and I'm here to testify concerning raised SB1088, AN ACT CONCERNING MEDICAL MALPRACTICE INSURANCE RATES.

The Connecticut Trial Lawyers Association supports the concepts of performing a study to determine the caused of the recent rise in medical malpractice premiums and to develop recommendations for real solutions to this problem.

This is not a new problem. It happened during the mid 1970's, it happened again during the mid 1980's and now again over the past two years.

And if we don't get to the bottom of what causes these insurance cycles and address those causes this will problem will surely happen again, the next time the economy goes into a recession.

There are a number of interrelated factors that contribute to these insurance cycles. There are economic factors such as lower returns on investments, the drop in the stock market and lower interest rates on bonds.

And that affects medical malpractice insurance more than most other lines of insurance because of the long lag time between the time the premium is collected and the time the claim is actually settled. Which is an average of about five years.

So we need to look at ways in which we can level



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TESTIMONY
OF
CONNECTICUT HOSPITAL ASSOCIATION
INSURANCE AND REAL ESTATE COMMITTEE
Thursday, March 13, 2003

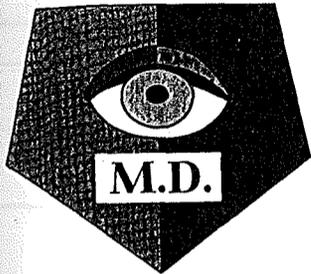
SB 351, An Act Concerning Deficiencies In Insurance Claim Information

The Connecticut Hospital Association (CHA) appreciates the opportunity to testify in support of SB 351, An Act Concerning Deficiencies In Insurance Claim Information.

SB 351 clarifies what constitutes a clean claim by codifying the Connecticut Insurance Department's Bulletin HC-51. HC-51 was developed by a working group of Connecticut's managed care industry, healthcare providers and the Connecticut Insurance Department to more clearly define the minimum criteria for the acceptance of a claim.

CHA was part of the working group that met and developed HC-51 and supports making the contents of HC-51 permanent by codifying its provisions.

Thank you for consideration of our position.



Connecticut Society of Eye Physicians
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Testimony of Steven Thornquist, M.D.
Before the Insurance Committee
On March 13, 2003

On

Committee Bill 351 An Act Concerning Deficiencies in Insurance Claim Information

Good Afternoon, Senator Crisco, Rep. Orefice and other distinguished members of the insurance committee. I am Steve Thornquist a board certified ophthalmologist practicing in Trumbull, Connecticut. I am here as an officer of the Connecticut Society of Eye Physicians (CSEP) an organization representing over 90% of the ophthalmologists practicing in Connecticut to support Committee Bill 351.

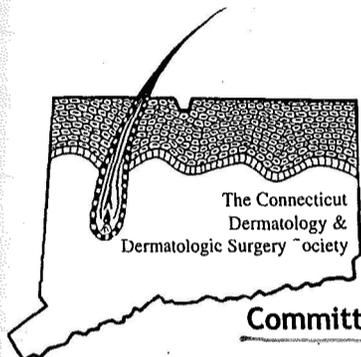
First, I would like to commend this committee for raising a bill that will help physicians, healthcare providers and patients achieve prompt payment.

It is frustrating, as a small business person to watch my accounts receivable go from 60 days to 120 days because HMOs have found a "loop hole" in the current system. Although, the Insurance Commissioner released a "clean claim" definition in the August 23, 2000 Bulletin, it was never codified in statute, thus providing a loop hole for delayed payment.

This loop hole has allowed the HMOs to stop the clocks on timely payment. They simply notify the physician that they need "additional information before settlement can be made". Many times this request is frivolous and insignificant in determining claim validity. It is merely a veiled attempt at delaying payments.

This unfair trade practice puts a tremendous administrative burden on the physician and/or other healthcare providers. Every year I see my medical colleagues taking early retirement or choosing new career paths outside of medicine. Clearly, it is becoming increasingly more difficult and more costly to practice medicine. We may not be able to fix all the problems ailing the healthcare system today, but by passing Committee Bill 351, carriers will be forced to recognize what the Insurance Commissioner has already determined in, Bulletin HC-56, to be a "clean claim". It will also codify the intent of the 1999 Prompt Payment Legislation and that is to require payment by HMO's to providers who submit clean claims within 45 days of receipt. This legislation is clearly being ignored!

Thank-you for your time and if I can answer any questions I will do so.



**Testimony of Debbie Osborn
Before the Insurance Committee
On March 13, 2003**

On

**Committee Bill 351 An Act Concerning Deficiencies in Insurance Claim
Information**

Good Afternoon, Senator Crisco, Rep. Orefice and other distinguished members of the insurance committee. My name is Debbie Osborn and I am the Executive Director for both the Connecticut Dermatology and Dermatologic Surgery Society and the Connecticut Society of Eye Physicians. I am here today to speak in favor of Committee Bill 351

It is never the intent of the legislature to pass a bill and then have it ignored. But that is precisely what has happened with Connecticut's Prompt Payment Law.

In 1998 the Connecticut Legislature passed legislation to address the problem of delayed payments by the HMOs to healthcare providers. This legislation required HMO's to pay physicians and other healthcare providers within 45 days of receiving a medical claim.

Unfortunately, the legislation was crafted in such a way that it allowed the HMO's to avoid this 45 day payment requirement by saying that the provider did not submit adequate information upon submission. Without a definition of clean claim in the statute, carriers were allowed to determine what they felt constituted a clean claim. By 2000, each insurance carrier was using this loophole as a delay tactic in paying claims. On August 23 of 2000, the Insurance Commissioner announced that new progress on the prompt payment law was made and the following bulletin, HC-56 was crafted to provide consistency in what constituted a "clean claim" for healthcare providers. The intent of this bulletin was to give relief to the physicians who still were not being paid promptly. Here it is 2003 and guess what? Physicians are still waiting 60,90,120 days for payment.

Committee Bill 351 simply codifies this same definition and forces all parties to acknowledge what truly is required to receive settlement on a healthcare claim.

I will leave you by saying in my position, I have seen tens of thousands of claims over the last six years that have been delayed 65-100 days in making payment, for no apparent reason. I have made hundreds of inquires on these claims only to be told "we are waiting for more information." The irony here is when no other information is given, the claim is paid but in 120 days vs. the 45 days it should have been paid in.

Please stop this unfair trade practice and allow physicians and other healthcare providers to be paid in 45 days!

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Quality is Our Bottom Line

**Connecticut Association of Health Plans
Testimony in Opposition to**

SB 351 AAC Deficiencies in Insurance Claim Information

**Insurance Committee Public Hearing
Thursday, March 13, 2003**

Good morning, Senator Crisco, Representative Orefice, members of the Insurance & Real Estate Committee. My name is Susan Halpin and I'm here today representing the Connecticut Association of Health Plans in opposition to SB 351 AAC Deficiencies in Insurance Claim Information.

In the year 2000, the Association participated in an organized effort, at the direction of the Department of Insurance (DOI) along with the Connecticut State Medical Society (CSMS), the Connecticut Hospital Association (CHA) and other provider groups to address issues related to the implementation of the prompt-pay laws that were passed previously by the legislature.

As you may recall, two separate prompt-pay laws were enacted. The first act required that health plans pay clean claims within 45 days or pay an interest penalty of 15%. The second act required that health plans inform providers within 30 days as to the deficiencies in any submitted claim and that upon receipt of the deficient information pay the claim within 30 days or be subject to a 15% interest penalty.

Upon implementation of these acts, both the provider community and the insurance community raised a number of questions as to what trigger started the 30 day clock ticking. From the health plan perspective, some claims were so deficient in the information they contained as to be unidentifiable. In simple terms, for instance, if a claim came in without an i.d. number and without name it would be kicked-out of the system automatically and therefore never even registered as a claim to begin with. Without a certain set of basic data elements, health plans cannot tell providers what information might be deficient.

In working with the DOI, CHA and the CSMS, we developed a consensus set of select criteria for both the HCFA 1500 and the UB 92 billing forms that must be complete in order for a claim to be considered a claim for purposes of the law. That agreement resulted in the attached bulletin being issued by the Department clarifying the law and the components needed to set the prompt-pay process in motion.

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While SB 351 nearly mirrors the claims bulletin issued by DOI, it differs in one critical regard. By virtue of the language that states "if the following information is completed and received by the insurer, the claim may not be deemed to be deficient in the information needed for processing a claim," it changes the intent of the language from determining what constitutes a claim to what constitutes a clean claim. These are two very different definitions. For instance, if all relevant fields on a claim are correctly submitted, but the accompanying medical records needed to approve the claim aren't included with it, then the insurer would have to either approve or deny the claim on the basis of the information submitted and wouldn't, under this legislation, have the ability to request additional information. Ironically, should this legislation pass it's likely that more, not less, claims will be denied upon initial submission because a plan would be forced to make a decision based upon the information available as opposed to requesting the additional information needed to support the claim. We urge your rejection the proposal.

Thank you for your consideration.

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STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Bulletin HC-56

CONNECTICUT GENERAL STATUTE §38a-816(15) AS AMENDED BY PUBLIC ACT 99-284 §30 REGARDING PROMPT PAYMENT OF ACCIDENT AND HEALTH CLAIMS

August 9, 2000

Section 38a-816(15) of the Connecticut General Statutes, as amended by section 30 of Public Act 99-284, (hereinafter, the "statute") concerns, in part, claims filed by health care providers and the timeframe for payment by insurers.¹ The statute requires insurers to pay interest if a claim containing all the information necessary for payment is not paid within 45 days of receipt. If a claim does not contain all the information necessary for payment, the insurer has 30 days to request additional information and 30 days after receiving the requested information to pay the claim without interest.

To implement the statute efficiently, a consensus on what constitutes a claim is needed. To this end, former Insurance Commissioner George M. Reider, Jr. organized members from Connecticut's managed care industry, providers, and the State of Connecticut Insurance Department to discuss and propose criteria for determining what constitutes a claim for the purposes of C.G.S. §38a-816(15).

The criteria suggested by the members would NOT define what constitutes a "clean claim" or a claim containing all the information necessary for payment by an insurer. The criteria would simply establish when there is enough information on a piece of paper or bit of electronic media submitted to an insurer to be considered a claim. Once identified as a claim, the insurer would determine whether the claim should be paid, denied, or requires additional information.

After reviewing the member's findings, Insurance Commissioner Susan F. Cogswell has determined that the Insurance Department shall use, and expects insurers and providers to use, the criteria set forth below to determine when information submitted to an insurer constitutes a claim and the 45 and 30-day time periods set forth in the statute begin. This bulletin is intended to define the minimum criteria for the acceptance of a claim; it does not guarantee payment. The best way to ensure prompt payment is to file a fully completed claim in accordance with an insurer's practices and procedures.

For information submitted on a HCFA 1500 form, as periodically updated and revised, the following minimum requirements must be complete and received by the insurer before the form will be considered a claim.

<u>Item Number</u>	<u>Item Description</u>
1a	Insured's ID number
2	Patient's name
3	Patient's birth date and sex
4	Insured's name
10a	Patient's condition – employment
10b	Patient's condition – auto accident
10c	Patient's condition – other accident
11	Insured's policy group number (if provided on I.D. card)

¹ For the purposes of this bulletin, the terms "claim for payment," "reimbursement to health care providers," "claim for reimbursement," "claim," "request," and "request for payment" used in the statute shall be collectively referred to as a "claim" or "claims."

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Bulletin HC-56

11d	Is there another health benefit plan?
17a	I.D. number of referring physician (if required by insurer)
21	Diagnosis
24A	Dates of service
24B	Place of service
24D	Procedures, services or supplies
24E	Diagnosis code
24F	Charges
25	Federal tax I.D. number
28	Total charge
31	Signature of physician or supplier with date
33	Physician's, supplier's billing name, address, zip code & phone

For information submitted on a HCFA UB-92 form, as periodically updated and revised, the following minimum requirements must be complete and received by the insurer before the form will be considered a claim.

<u>Item Number</u>	<u>Item Description</u>
1	Provider name and address
5	Federal tax I.D. number
6	Statement covers period
12	Patient name
14	Patient's birthdate
15	Patient's sex
17	Admission date
18	Admission hour
19	Type of admission
21	Discharge hour
42	Revenue codes
43	Revenue description
44	HCPCS/CPT4 codes
45	Service date
46	Service units
47	Total charges by revenue code
50	Payer I.D.
51	Provider number
58	Insured's name
60	Patient's I.D. number (policy number and/or social security number)
62	Insurance group number (if on I.D. card)
67	Principal diagnosis code
76	Admitting diagnosis code
80	Principal procedure code and date
81	Other procedures code and date
82	Attending physician's I.D. number



Susan F. Cogswell
Insurance Commissioner

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Connecticut State Medical Society Testimony on
Senate Bill 351 An Act Concerning Deficiencies in Insurance Claim Data
and
Senate Bill 1088 An Act Concerning Medical Malpractice Insurance Rates
Presented to the Insurance and Real Estate Committee
March 12, 2003

Senator Crisco, Representative Orefice, members of the Insurance and Real Estate Committee. My name is Dr. David Parke, an eye physician from Wallingford Connecticut and Chairman of the Connecticut State Medical Society Committee on Legislation. Thank you for the opportunity to provide comments today regarding Senate Bill 351 An Act Concerning Insurance Claims Data and Senate Bill 1088 An Act Concerning Medical Malpractice Insurance Rates.

The Connecticut State Medical Society (CSMS) supports Senate Bill 351. This General Assembly has passed legislation requiring health insurance companies to compensate physicians for their services in a timely manner or face the possibility of penalties for failing to do so. Insurers are granted additional time to pay claims when more information is necessary regarding the services provided. However, current statute that lacks an adequate definition of a "clean claim" has allowed insurers to abuse the law, obtaining additional time by returning claims for information they deem to be missing that is irrelevant or not necessary to identify the physician, patient, insured, or service provided. This legislation will clearly define the information needed in order for a claim to be paid in a timely manner.

When physicians bill for services they use standard claims form, most often the HCFA 1500 or HCFA UB-82, utilizing standard codes known as CPT-3 codes. As you can see from the proposed legislation, these forms require the submission of a great deal of information. I can think of no information not contained in these forms that has any relevance to the service provided or that would have any impact on appropriate reimbursement. Yet, we are continually contacted at CSMS by physicians who have claims denied or delayed when all of this information has been provided. This is unfair, and abuses the intention of this general assembly's timely payment laws. We ask you support of this legislation.

Regarding Senate Bill 1088 An Act Concerning Medical Malpractice Insurance Rates. During the 2002 session of the General Assembly, CSMS sought legislation that would have required a study of the pending crisis of the availability and affordability of medical

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Christine C. Cappiello
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Anthem.

March 13, 2003

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

SB 351 An Act Concerning Deficiencies in Insurance Claim Information

Good morning, Senator Crisco, Representative Orefice and members of the Insurance Committee, my name is Christine Cappiello and I am the Director of Government Relations for Anthem Blue Cross and Blue Shield. I am here today to speak in strong opposition to **SB 351 An Act Concerning Deficiencies in Insurance Claim Information**

Anthem is in strong opposition to **SB 351** because it essentially says that a claim only needs these fields to be considered a "clean claim" and therefore ready for processing. If we need something other than these fields, such as medical records, and we don't receive those in the 45 day time period from the provider that we request them from, we would be subject to paying interest for something that is not in our control. We need this information in order to properly process a claim and ensure that our members are receiving the quality care they deserve.

In the summer of 2000, the health plan industry, the CT. State Medical Society, the CT. Hospital Association under the guidance of the Department of Insurance, agreed to fields needed in a claim in order to get it started for processing, but it allowed for us obtain all necessary information to complete the processing of the claim before being subjected to the 45 day interest payments. Once these elements and process were agreed to, the Department of Insurance issued a bulletin. Since that time, the system seems to be working well and we are unaware of any problems. This bill will put that hard work and agreed to process in jeopardy.

I would also like to remind the Committee about HIPAA (Health Insurance Portability Accountability Act) Transaction Code Sets and administrative simplifications that are due to become active in October of this year. HIPAA is a federal statute that seeks bring uniformity to the health care industry through various administrative simplifications; one of those simplifications is a standard uniform set of code sets that are used by health plans and providers for processing claims. As the industry changes, the federal government will be adding and deleting "code sets". This legislation will mean that as these code sets change, we will be subjected to potentially paying interest for something that is not in our control because we will need different information to process claims as set by the Federal government.

We ask the committee to oppose this legislation for these reasons and I will address any concerns that you may have.

Decide to be healthy.SM

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