Legislative History for Connecticut Act

2005

Act Number: 97

Bill Number: 1297

Senate Pages: Senate: 1840-1847 — 8

House Pages: House: 5194-5198 — 5

Committee: Insurance: 2298-2299, 2408-2412 — 7

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

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S-509

CONNECTICUT
GEN. ASSEMBLY
SENATE

PROCEEDINGS
2005

VOL. 48
PART 6
1617-1959

Have all Members voted? Senator Finch. Senator Fasano. Senator Guglielmo. If all Members have voted, machine will be closed. Clerk will, not yet, not yet. Give Tony a break here. It's the big vote of the session, Tony.

If all Members have voted, the machine will be closed. The Clerk will please announce the tally.

THE CLERK:

Motion is on passage of S.B. 846 as amended.

Total number voting, 35; necessary for adoption, 18. Those voting "yea", 29; those voting "nay", 6. Those absent and not voting, 1.

THE CHAIR:

Bill is passed. Mr. Majority, Mr. Clerk.

THE CLERK:

Calendar Page 5, Calendar 225, File 245, S.B. 1297, An Act Concerning Managed Care Grievance Procedures, Favorable Report of the Committee on Insurance.

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

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

THE CHAIR:

On acceptance and passage, will you remark? Senator Crisco.

SEN. CRISCO:

Yes, Mr. President. Mr. President, presently there is a process where a provider or insurer can appeal an MCO action, a managed care organization action, or inaction.

What this bill does, this makes violating certain grievance requirements an unfair and deceptive insurance practice under the Connecticut Unfair Insurance Practices Act. A person in violation of one of its provisions is subject to various monetary penalties.

And what will happen is that this bill also requires that a managed care company organization pay a $20 fine for each time it does not resolve a grievance within the required period of 60 days.

Under the bill, this bill is to be deposited into the Insurance Fund. This is basically sound public

policy and pertains basically to when coverage is denied.

THE CHAIR:

On the bill, will you remark further? On the bill, will you remark further? If not, Senator Crisco, Senator DeLuca.

SEN. DELUCA:

Thank you, Mr. President. A question to the proponent, if I may, through you.

THE CHAIR:

Please proceed, Senator.

SEN. DELUCA:

Through you, Mr. President, I heard the Senator Crisco say something to the Insurance Act. And I'm looking through the bill, and I, it is my understanding this is only to do with grievances and the procedures in establishing a fine. Is that true, through you, Mr., if there is another purpose to this, please point it out, which line. Thank you, Mr. President.

THE CHAIR:

Senator Crisco, do you care to respond?

SEN. CRISCO:

Yes, Mr. President. Through you to Senator DeLuca, I'm sorry he did not hear me clearly. I referred to the Connecticut Unfair Insurance Practices Act.

THE CHAIR:

Senator DeLuca.

SEN. CRISCO:

Which covers--

THE CHAIR:

I'm sorry.

SEN. CRISCO:

Which covers the grievance procedures.

THE CHAIR:

Senator DeLuca.

SEN. DELUCA:

Thank you. I thought that you were referring to that in the bill. Thank you. Second question is we now have a grievance procedure, and it is my understanding that when a procedure, when a procedure is not adhered to or the, we're talking about the internal procedures of the managed care company now.

When a patient makes a grievance and applies, and that is not given in a certain amount of time, it

automatically goes to the ombudsman. Am I not correct under that, Sir, through you, Mr. President?

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

Yes, that is correct.

THE CHAIR:

Senator DeLuca.

SEN. DELUCA:

So what I'm grasping here is what are we doing that is really much different other than is it just the fine? Are we changing the procedures? I don't see any change in procedure, through you, Mr. President.

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

Mr. President, through you to Senator DeLuca, basically what the bill does, it substantiates that when the grievance procedure is not followed, there is a violation. And a person in violation of one of these provisions is subject to various monetary penalties, which basically relates to the, to a

different penalty in addition, I believe, to the $25 fine.

THE CHAIR:

Thank you, Senator. Senator DeLuca.

SEN. DELUCA:

And thank you. Lastly, through you, Mr. President, have we had a number of problems in this procedure that has predicated this law to come, this proposal to come through? Has there been a problem? Have the managed care companies been violating this, through you, Mr. President?

THE CHAIR:

Senator Crisco.

SEN. CRISCO:

Yes, Mr. President, through you to Senator DeLuca, yes. According to public testimony, there has been a problem with the process.

THE CHAIR:

Senator DeLuca.

SEN. DELUCA:

Thank you, and thank you, Senator Crisco. It is my understanding that reading over the file copy and reading some of the testimony that there hasn't been a

number of complaints. There may have been a few complaints.

And in my opinion, this is one of those bills that is repetitive, and I know from the previous debate in the last few weeks that we don't do things and repeat bills. I was told that on a previous bill. So I think this is a repetitive issue, and, therefore, I would oppose it. I don't think it's necessary. Thank you, Mr. President.

THE CHAIR:

Thank you, Senator. Will you remark further? Senator Crisco.

SEN. CRISCO:

Yes, Mr. President. Mr. President, I have the utmost respect for Senator DeLuca's opinion. However, we disagree in regards to his fact finding. And, Mr. President, I ask for a roll call vote.

THE CHAIR:

Roll call vote will be ordered. Will you remark further on the bill? Will you remark further? If not, Clerk will announce the pendency of a roll call vote, machine is open.

THE CLERK:

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

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

THE CHAIR:

Have all Members voted? Senator Fonfara. Senator Harris. If all Members have voted, the machine will be closed. The Clerk will announce the tally.

THE CLERK:

Motion is on passage of S.B. 1297.

Total number voting, 35; necessary for adoption, 18. Those voting "yea", 25; those voting "nay", 10. Those absent and not voting, 1.

THE CHAIR:

The bill is passed. Mr. Clerk.

THE CLERK:

Calendar Page 6, Calendar 315, File 422, Substitute for S.B. 1312, An Act Concerning Food Allergies and the Prevention of Life-Threatening

H-943

CONNECTICUT
GEN. ASSEMBLY
HOUSE

PROCEEDINGS
2005

VOL. 48
PART 17
4936-5239

REP. FERRARI: (62nd)

I pledge allegiance to the flag of the United States of America, and to the republic for which it stands, one nation, under God, indivisible, with liberty and justice for all.

SPEAKER AMANN:

Is there any business on the Clerk's desk?

CLERK:

Only today's Calendar, Mr. Speaker.

SPEAKER AMANN:

Thank you. Are there any announcements or introductions? Announcements or introductions? Announcements or introductions?

Will the Clerk please call Calendar Number 515.

CLERK:

State of Connecticut House of Representatives, Calendar for Monday, May 23, 2005. On Page 28, Calendar Number 515, House, I'm sorry, Senate Bill Number 1297, AN ACT CONCERNING MANAGED CARE GRIEVANCE PROCEDURES, Favorable Report of the Committee on Judiciary.

SPEAKER AMANN:

Representative O'Connor.

REP. O'CONNOR: (35th)

Thank you, Mr. Speaker. I move acceptance of the Joint Committee's Favorable Report and passage of the Bill.

SPEAKER AMANN:

Motion is on acceptance of the Joint Committee's Favorable Report and passage of the Bill. Is there objection? If not, Representative, you have the floor, Sir.

REP. O'CONNOR: (35th)

Thank you, Mr. Speaker. This Bill makes violating certain grievance requirements an unfair and deceptive insurance practice.

Under the Connecticut Unfair Insurance Practices Act, a person in violation of one of its provisions is subject to various monetary penalties, therefore the result in a minimal revenue gain to the state according to this Bill.

What we're trying to do is make it clearer, make the grievance process clearer for enrollees to appeal their managed care organization's actions or inactions that meet specified requirements.

It also makes violating the grievance requirements subject to a fine of up to $1,000 for each violation to a maximum of $10,000. And if a person knew or should have known his action was a violation, the penalty goes up to $5,000 for each violation to a maximum of $50,000 in any six-month period.

It also includes a license suspension, a revocation, and restitution of any amounts obtained through the violation.

To continue further, it requires the managed care organization to notify the enrollee and his provider, of the grievance process when it denies a service admission or stay extension ordered by the provider. I move acceptance.

SPEAKER AMANN:

Will you remark further? Will you remark further? Will you remark further? Will you remark further?

If not, staff and guests please come to the Well of the House. Will Members please take your seats. 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.

SPEAKER AMANN:

Have all the Members voted? Have all the Members voted? If all the Members have voted, please check the board to make sure that your vote is accurately cast.

If all the Members have voted, the machine will be locked and the Clerk will take a tally.

It will be noted that the Speaker votes in the affirmative. Representative Merrill. Representative Merrill, for what purpose do you stand, Madam?

REP. MERRILL: (54th)

In the affirmative.

SPEAKER AMANN:

Thank you, Madam. Representative Merrill in the affirmative. Will the Clerk please announce the tally.

CLERK:

Senate Bill Number 1297, in concurrence with the Senate.

Total Number Voting 142

Necessary for Passage	72
Those voting Yea	142
Those voting Nay	0
Those absent and not voting	9

SPEAKER AMANN:

The Bill passes. Will the Clerk please call Calendar Number 371.

CLERK:

On Page 24, Calendar Number 371, Senate Bill Number 946, AN ACT CONCERNING THE SOLICITATION OF CHARITABLE FUNDS ACT, Favorable Report of the Committee on Judiciary.

SPEAKER AMANN:

Representative Stone.

REP. STONE: (9th)

Thank you, Mr. Speaker, and good afternoon. I move acceptance of the Joint Committee's Favorable Report and passage of the Bill in accordance with the Senate.

SPEAKER AMANN:

Thank you. The question is on acceptance of the Joint Committee's Favorable Report and passage of the Bill. You may proceed, Sir.

JOINT
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PART7
1968-2317

2005

ATTY. GEN. RICHARD BLUMENTHAL: It is indeed. And I'll tell you something, Representative Megna, what's frightening about that statistic is that, first of all, there are such a large number of complaints, but second, that our success rate is so high.

REP. MEGNA: Yeah.

ATTY. GEN. RICHARD BLUMENTHAL: Because think of all the other people out there who either don't know--

REP. MEGNA: Absolutely.

ATTY. GEN. RICHARD BLUMENTHAL: --or simply don't have the motivation to come to our, you know, some of them probably just don't get the treatment and suffer as a result.

REP. MEGNA: Yes. And it's a tremendous burden, not only on those people, but on the taxpayers, in terms of your office also too.

ATTY. GEN. RICHARD BLUMENTHAL: Correct.

REP. MEGNA: Let's--

ATTY. GEN. RICHARD BLUMENTHAL: It's a burden on our office and on other agencies of government.

REP. MEGNA: Okay, thank you.

ATTY. GEN. RICHARD BLUMENTHAL: Thank you.

the doctor really wants to provide the quickest, most effective treatment.

And that's why we urge respect for those decisions.

SEN. CRISCO: Any other questions? Thank you, Mr. Attorney General.

ATTY. GEN. RICHARD BLUMENTHAL: Thank you.

SEN. CRISCO: This will conclude the public official part of the hearing. Unless there's anybody else, we will proceed to the public part. Dr. James Weisz for Senate Bill 1297. Is Dr. Weisz here?

DR. JAMES WEISZ: Good morning, Senator Crisco, Representative O'Connor, the distinguished Members of this Committee.

My name is James Weisz. I am a board certified ophthalmologist, specializing in vitreoretinal disease and surgery, practicing in Bridgeport and New Haven.

I am here today as an Officer of the Connecticut Society of Eye Physicians, an organization representing more than 300 Connecticut ophthalmologists, in support of Senate Bill 1297.

Senate Bill 1297, AN ACT CONCERNING MANAGED CARE GRIEVANCE PROCEDURES, is simply an advocacy bill for patients who do not have the medical knowledge, expertise, or resources to appeal decisions made by managed care

organizations, when certification of an admission, service, or extension of stay, as ordered by their physician, is denied.

This Bill, in addition to requiring that the enrollee be notified of grievance procedures, also requires the enrollee's healthcare providers be notified.

We strongly believe that, as patient advocates, we should be informed on the managed care organization's process for filing a grievance and that we should be able to file a grievance on the patient's behalf.

Senate Bill 1297 also addresses the problem of the prolonged appeals process, delays in determinations on appeals, and other practices used by managed care organizations to delay payment.

Currently, there is no incentive for a MCO to make a timely determination on an appeal. They may take 120 days or even 6 months to make a determination, without any penalty.

It is true that the managed care organizations sometimes disregard the Connecticut Statute requiring interest payment on claims which are not settled after 45 days.

If the MCO finally rules in favor of an enrollee on a particular service after six months of review, they simply pay the claim and disregard the interest.

JOINT
STANDING
COMMITTEE
HEARINGS

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2318-2670

2005

Quality is Our Bottom Line

The Connecticut Association of Health Plans
Testimony Before The
Insurance and Real Estate Committee
March 15, 2005

Regarding

SB 1297 AAC Managed Care Grievance Procedures

The Connecticut Association of Health Plans respectfully urges rejection of SB 1297, because it will generate significant new paperwork with little if any benefit for the system. Providers already have their own contractual appeal rights and also already have the right to represent patients under the state's external appeals law, if the physician is invited to do so by the member. The section of the law that would be amended by SB 1297 deals with the rights of members *vis a vis* their managed care plans, and adding new layers of paperwork without any real benefit for members is a bad idea.

280 Trumbull Street | 25th Floor | Hartford, CT 06103-3597 | 860.275.8372 | Fax 860.541.4923 | www.ctahp.com

Testimony of
James Weisz, M.D.
On behalf of the Connecticut Society of Eye Physicians
On
SB 1297 An Act Concerning Managed Care Grievance Procedures
In the Insurance and Real Estate Committee
On
March 15, 2005

Good morning Senator Crisco, Representative O'Connor and other distinguished members of this committee. For the record, my name is Jamie Weisz I am a board certified ophthalmologist specializing in Vitreo-retinal disease & surgery practicing in the Bridgeport, New Haven area. I am here today as an officer of the Connecticut Society of Eye Physicians, an organization representing more than 300 Connecticut ophthalmologists in support of SB 1297

SB 1297 An Act Concerning Managed Care Grievance Procedures is simply an advocacy bill for patients, who do not have the medical knowledge, expertise, or resources to appeal decisions made by Managed Care Organizations when certification of an admission, service or extension of stay as ordered by their Physician is denied.

This bill, in addition to requiring that the enrollee be notified of grievance procedures, also requires the enrollee's healthcare providers be notified. We strongly believe that as patient advocates we should be informed on the Managed Care Organization's process for filing a grievance, and that we should be able to file a grievance on the patient's behalf.

SB 1297 also addresses the problem of the prolonged appeals process, delays in determinations on appeals, and other practices used by Managed Care Organizations to delay payment. Currently, there is no incentive for a MCO to make a timely determination on an appeal. They may take 120 days, or even 6 months, to make a determination - without any penalty. It is also true that Managed Care Organizations sometimes disregard the Connecticut Statute requiring interest payment on claims which are not settled after 45 days. If a Managed Care Organization finally rules in favor of an enrollee on a particular service after six months of review, they simply pay the claim and disregard the interest. SB1297 addresses this egregious practice by implementing a fine of $25 on Managed Care Organizations who fail to make their determinations within the statutory limit.

Unfortunately, monetary fines are the only buttons hot enough to move the Managed Care Organization's utilization review and appeals departments into action.

Thank you for your time and I will entertain any questions at this time.

TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
INSURANCE AND REAL ESTATE COMMITTEE
Tuesday, March 15, 2005

SB 1297, An Act Concerning Managed Care Grievance Procedures

HB 6914, An Act Concerning Utilization Review Determinations And Appeals Under Health Insurance Plans

The Connecticut Hospital Association (CHA) is submitting this testimony in support of **SB 1297, An Act Concerning Managed Care Grievance Procedures** and **HB 6914, An Act Concerning Utilization Review Determinations And Appeals Under Health Insurance Plans.** SB 1297 seeks to require that providers must be notified, along with enrollees (as required under existing law), when a decision has been made by the utilization review company not to certify an admission, service or extension of a stay ordered by the provider. In addition, the bill seeks to impose a fine of twenty-five dollars for each failure to provide notice. HB 6914 seeks to require that determinations not to certify a service for medical necessity must be explained and that there is a presumption that services ordered by licensed participating providers operating within their scope of practice are medically necessary.

As drafted, both of these bills reflect sound public policy. Providers need to be told by utilization review companies when coverage for a service is being denied. In addition, if the service is being denied for medical necessity then the onus should be on the utilization review company to explain why its judgment should override the judgment of the practitioner that ordered the service, given that the practitioner was selected by the managed care company as being a necessary part of their network of providers.

Connecticut hospitals continue to face a series of daunting fiscal challenges, including inadequate reimbursement from the Medicare and Medicaid programs, a $22 million dollar a year cut in State Administered General Assistance (SAGA) funding, a shortage of healthcare workers, and escalating costs in areas such as pharmaceuticals, blood and blood products, and particularly medical and general liability premiums. In addition, our hospitals must expend their limited resources on quality improvement and facility modernization, advances in new healthcare technology, and disaster and emergency planning programs.

The competing pressures of government funding cuts, the need to attract and maintain a superior workforce, rising input costs, and the continuous effort to improve the care given have put Connecticut's hospitals in a financially tenuous position. In 2004, 22 of the state's 30 acute care hospitals ended the year unable to collect enough funds to cover the cost of care delivered to those patients.

Affording providers notice and a presumption that they do right, not wrong, makes sense. Therefore, CHA asks that you support SB 1297 and HB 6914 as these bills present two opportunities to make needed improvements to the current system.

Thank you for your consideration of our position.

For additional information, contact CHA Government Relations at (203) 294-7310.

SAF:kas

Connecticut State Medical Society Testimony in Support of
Senate Bill 1297 An Act Concerning Managed Care Grievance Procedures
And
House Bill 6914 An Act Concerning Appeals Under Health Insurance Plans
Presented to the Insurance and Real Estate Committee
March 15, 2005

Senator Crisco, Representative O'Connor and members of the Insurance and Real Estate Committee, on behalf of the Connecticut State Medical Society (CSMS) thank you for the opportunity to present this testimony today in support of Senate Bill 1297 An Act Concerning Managed Care Grievance Procedures and House Bill 6914 An Act Concerning Appeals Under Health Insurance. We respectfully ask for your support of this legislation.

Senate Bill 1297 An Act Concerning Managed Care Grievance Procedures requires that a health insurance enrollee *and his/her* provider be informed of the insurers grievance procedures when the insurer decides not to certify an admission, service or extension of stay ordered by the provider. In addition, because physicians often act as advocates for their patients throughout the grievance process, the bill would codify that notification and review requirements would commence if a complaint is filed by a person acting on behalf of the enrollee. Finally, SB 1297 implements a modest fine against any managed care organization that violates notification requirements.

House Bill 6914 An Act Concerning Appeals Under Health Insurance Plans requires that when a health insurer does not certify an admission, procedure or extension of stay they provide a written explanation as to why they deemed the admission, service, or procedure not to be medically necessary. Currently, insurers must provide information regarding procedures to initiate an appeal but are not required to provide an explanation regarding their decision.

More incongruous to common sense and rationality is the fact that currently it has become incumbent upon physicians, licensed and highly trained health care professionals, to justify whether or not a service is medically necessary. The legislation before you today may a critical and necessary change to that mindset. House Bill 6914 clearly establishes that the presumption of medical necessity exists if the admission, service, procedure or extension is ordered by a licensed participating provider and is within the scope of the provider's scope of practice. It then, rightly so, is incumbent upon the insurer to prove that the service was not medically necessary. The insurer must also provide for a hearing prior to making a final decision not to certify.

Notification of procedures, appropriate determinations of medical necessity made by the appropriate medical provider and explanation of reasons not to provide necessary care all seem like common sense. Unfortunately, they must be put into state statute. Please support Senate Bill 1297 and House Bill 6914.