PA10-19

HB5303

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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.

000893

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. Will you explain the bill please, sir.

REP. FONTANA (87th):

Thank you, Mr. Speaker.

Mr. Speaker, this bill and claims denial data to the information that managed care organizations annually must report to the insurance commissioner. It requires the commissioner to post the claims denial information on the Insurance Department's website and to include the data in the consumer report card on health insurance carriers in Connecticut.

I urge passage and ask to comment further.

DEPUTY SPEAKER GODFREY:

Will you remark further on the bill?

Representative Fontana.

REP. FONTANA (87th):

Thank you, Mr. Speaker. I appreciate you --

DEPUTY SPEAKER GODFREY:

You didn't need my permission. Go ahead, sir.

REP. FONTANA (87th):

All right. Thank you.

Mr. Speaker, I just want to explain briefly. This bill is pattered on an existing practice maintained in the State of California.

Currently, nationwide there is little, if any information on claims denial data collected by our states on the practice of insurance companies in those states.

And clearly, one of the interesting things that people want to know about when they evaluate the quality of their health care plans is the so-called medical loss ratio. Another thing they'd like to know is whether, in fact, there is a very high level of claims denials and whether they vary from company to company.

This would simply require the companies to provide that level of transparency and accountability that they currently do for a variety of other forms of information to the department and to consumers.

It's a good bill. It has no fiscal impact and hired the members' support. Thank you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Thank you, sir.

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Representative Alberts.

REP. ALBERTS (50th):

Thank you, Mr. Speaker.

I do share the protagonist's -- the proponent's comments on this bill.

I agree that this is a fair representation of the bill that's before us, that it covers all of the aspects and that this would be a good bill and deserves passage. Thank you.

DEPUTY SPEAKER GODFREY:

Thank you, sir. Will you remark further on the bill? Will you 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 have voted. The machine will be locked. The Clerk will take a tally. And the Clerk will announce the tally.

THE CLERK:

House Bill 5303.

Total Number voting 145

Necessary for adoption 73

Those voting Yea 145

Those voting Nay 0

Those absent and not voting 6

DEPUTY SPEAKER GODFREY:

The bill is passed.

The House will stand at ease.

(Chamber at ease.)

DEPUTY SPEAKER GODFREY:

The House will come back to order.

The Clerk please call Calendar 201.

THE CLERK:

On page 13, Calendar 201, substitute for House Bill Number 5346, AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE WELL-BEING OF ALL CONNECTICUT CHILDREN AND REQUIRING AN ANNUAL REPORT CARD EVALUATING STATE POLICIES AND PROGRAMS IMPACTING CHILDREN, favorable report by the Committee on Human Services.

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We'll now proceed to bill 5303. Steve Karp to be followed by Matt Katz. Steve Karp here?

STEPHEN KARP: Good afternoon. I'm Stephen Karp, Executive Director for National Association of Social Workers, Connecticut Chapter. And we are in favor of Bill 5303. The Office of Health Care Advocate has tracked the number of denials of care brought to their office. Will note and we do have some data in our testimony.

But I'll just note that from 2008 to 2009, there was a 50 percent increase in one year in the number of denials that they had dealt with. And I think this really speaks to the importance of having claims, denial information made public in the way that allows for tracking trends and informing purchases of health insurance.

One of the most common complaints that -- that any (inaudible) as Connecticut against bar members is regarding managed care organizations either denied coverage or denied either initial treatment or denied continuing treatment. This corresponds with additional data from the Office of Health Care Advocate that shows that mental health is consistently each year the category with the highest frequency of complaints.

Again, we believe that this bill shed light in information and on the prevalence of denials of care. There is one are we'd like to see the bill modified on. And that has to do with including -- actually having separate provisions for reporting denial of care -- in denial of claims based on mental health versus physical health.

Our big concern is that we're not convinced at all that mental health parity really exists in this state in many ways. And we believe that by being able to track the mental health side versus the physical side made arguments that you all listen to every year between providers and insurers. We can now have real data and the public can have real data.

And there -- there is precedence for that because in this -- later in this section -- in this current law, when you get into the report card. The report card actually has a separate reporting for mental health. So, we would say that we would like to see that be -- be the case.

One of our concerns really is -- I'll give you an example, is we know a major managed care organization in Connecticut that consistently denies appropriate treatment for eating disorders. Consistently wants people to go into out patient when people really need in-patient. And eating disorders are an extremely difficult disorder to treat and can very often be life threatening.

Yet, we consistently -- I remember issues we had to fight with the insurers around that. So, we'd like to be able to see through this field to be able to start tracking how much is it really is denying care and what percentage is physical. What percentage is mental health. So that's really the area we ask for adjusting.

And finally, we just say that, you know, this bill gives greater transparency and will provide a valuable information that allows consumers and employers to be well educated

and better informed as they purchase health care insurance. So we ask for your support.

SENATOR CRISCO: Thank you, Steve.

Any questions?

Chairman Fontana.

REP. FONTANA: Thanks, Mr. Chairman.

Thank you Steve as always for your testimony. And we'll take your suggestion under advisement.

STEPHEN KARP: Thank you.

SENATOR CRISCO: Any other questions?

Any questions?

No.

Thank you.

Matt followed by Brian Anderson.

MATTHEW KATZ: Chairman Crisco, Chairman Fontana, if I might ask a question real quick? I can -- that was quick. You did that on purpose. I know you did. If -- if I --

SENATOR CRISCO: You're all through, sir. I'm sorry.

MATTHEW KATZ: I'm up on the next bill, you're stuck with me. Actually I was wondering if I could testify both on 5300 and 258 at the same time to reduce the amount of people coming up and eliminating some time, if that's appropriate?

HB5303

SENATOR CRISCO: Yes, quickly.

MATTHEW KATZ: Yes. And I will be as quick as possible.

Senator Crisco, Representative Fontana and distinguished members of the Insurance and Real Estate Committee, my name is Matthew Katz and I'm the Executive Vice President of the Connecticut State Medical Society. And on behalf of our more than 7300 members, thank you for the opportunity to testify today in support of Senate Bill 258, AN ACT CONCERNING APPEALS OF HEALTH INSURANCE BENEFITS. And House Bill 5303, AN ACT ON REQUIRING A RECORDING OF CERTAIN HEALTH INSURANCE CLAIMS.

Together these bills make significant strives in providing greater transparency to the physician and provider community as well as the patient community making informed decisions. The most critical aspect contained in Senate Bill 258, is the presumption of care being necessary in the requirement that the insurer determine with documentation the rationale for rejection of medically necessary care.

This puts the presumption where it should be. In care being provided first and foremost allows the patient as well as the physician to focus on that care. And if in fact the insurer believes otherwise, they are then obligated to provide that necessary documentation so an informed decision can be made.

Secondly, that allows the physician and the patient to determine if documentation is provided whether or not an appeal is in fact

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necessary. They may learn some critical information that may make them reconsider. In fact, whether or not that care should be provided in that manner.

So, we have commend you and support that aspect of the bill. CSMS does request, however, an amendment be made to this bill to further strengthen the bill to allow multiple claims to be filed under the same service provision and diagnosis code for the services to ensure that there's not duplication of claims, duplication of effort if the same outcome is expected.

In other words, if it's the same service, the same diagnosis, you should be able to group those claims together under one claim to ensure in fact if there is denial then an appeal can be done expeditiously in all cases.

We also ask that you support 5300, but we ask the committee to reconsider some aspects of this to ensure that not only this information be provided to the Department of Insurance in a comprehensive manner but also be provided to the public, whether it's through the consumer report card or posted on the -- the website.

As we've seen today in the Hartford Courant, that information is provided by the Health Care Advocate and posted but it is not presently posted when in fact there is a denial to the department. Only when that denial or that information goes to the health care advocate, we would ask for some consistency to ensure easier review by the public.

Thank you both. Thank you very much on those two bills. We ask for your strong support.

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SENATOR CRISCO: Thank you, Matt.

Any questions?

Any questions?

Thank you very much. Brian Anderson. Is Brian here?

Jamie? Is Jamie here?

Followed by -- I'm not sure. Jacqui.

Right there Jamie. The name the -- the red light. You're close.

JAMIE MOTT: Okay. So, hello. My name is Jamie Mott. I'm a 32 year old and I have a chronic repetitive strain injury called myo fascia pain syndrome. My condition is a work-related injury that I got when I was 21 while using the computer extensively in college. Since then the injury has become progressively worse and because of -- so, I but -- but I've continued to work while having this injury but because of this I've been in chronic pain that is unrelenting for the last like 11 years.

HB5303

Because of my injury happening in college instead of a job, I wasn't eligible for getting worker's compensation insurance benefits. So I have been unlucky to be fully reliant on health insurance for medical support for my condition. The reason I wanted to come here to speak today is tell you of the horror and the heartbreak that I've experience.

I hope that together we can put legislation in place so it protects the sick and injured as

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well as the healthy consumers of health insurance. This bill would prevent consumers from wasting their time and money while giving them also tools to advocate for their care and their health.

So, I'm a certified ESL teacher but because of the physical demands of the profession I'm unable to do what I went to school to do. Instead I work part time as a tutor and substitute teacher. These professions however, almost never provided health insurance. So previous to this year, I was living in California where companies allow us to extend our Cobra.

So -- but with Cobra it was very expensive with very high deductibles. And didn't cover the treatment I needed for my condition. So I lived in my parents house in order to pay for insurance but then also paid for out of -- out of pocket medical costs which weren't covered. Which is about 80 -- 70 percent of my income.

So I looked into individual plans that were less expensive than Cobra but I was denied multiple times for having the pre-existing condition. It was a complete waste of my time and extremely humiliating and it made me feel very angry, helpless and hopeless. It was also very scary when I moved to Connecticut and went without insurance because I learned I couldn't carry my Cobra out of state.

I just -- I guess -- if this legislation passed it would require the company's to disclose this information so that way, you know, as a consumer I would know is it even worth my time to apply for insurance here or is anything going to be covered that I actually need. So, instead of playing like

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all these loops of guessing and hoping a doctor might be able to, you know, advocate for me and tell me what's going on -- at least I would know if I had a fighting chance.

And know how to spend my time fighting for the care that I need.

SENATOR CRISCO: Well thank you, Jamie.

JAMIE MOTT: Thank you.

SENATOR CRISCO: Any questions of Jamie?

Thank you very much. We appreciate it.

JAMIE MOTT: Okay.

SENATOR CRISCO: Is it Miss Denski? Is she here? Jacqui Denski. She's not here.

Doctor Ehlers.

WILLIAM EHLERS: Thank you again. Senator Crisco, Representative Fontana and other members of the committee. I'm going to drop my written testimony and in interest of time I'd like to speak very specifically to one aspect of this. We -- we applaud you for raising this -- this bill and we think that it -- it's in the best interest of consumers and providers.

HB5303

We do think that it could be strengthened by adding some specific language that we have included in our testimony, in our submitted testimony. The situation occurs not infrequently when a patient will come in for -- for a particular reason and they will either bring up another concern or we will notice something that we think needs to be addressed.

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You know, an eye lid lesion that needs to be biopsied and sent to the pathologist for analysis. If we do two things the same day and submit them with appropriate documentation and coding, very often one or the other will be denied. Either the examination code or the procedure code.

Because we know this, this sometimes forces us to say okay do we really want to bring this patient back another day. Or do we go ahead and do what we think needs to be done in the interest of good medicine and efficiency. And do everything that is necessary. Submitting it and knowing that we probably would not get paid for one or the other.

The other choice is obviously to bring them back to introduce some additional and inefficiencies to care delivery. Also sometimes to cause some anxiety as there is delay in providing a biopsy result or things of that nature.

So we think that it would be improved if this included not only denials and appeals but partial denials and things that can be partially appealed. We would like the specific reason for the denial unlimited. And the word experimental added to the list of reasons why something can be denied.

We have been frustrated to sometimes find things that we've known to be standard of care and mainstream medical practice denied as experimental sometimes in what seems to be sort of a broadly decided -- just a policy that denies things that have been previously been paid. And so we do think that this would be an important piece of legislation for both

consumers and providers. And I thank you. And will take any questions.

SENATOR CRISCO: Thank you, Doctor, for taking time from your busy schedule to be with us.

Any questions for Doctor Ehlers?

Thank you very much.

Bill Shortell.

BILL SHORTELL: Good afternoon. I'm Bill Shortell, I'm the Political Director of the Eastern Territory of Machinist Union. We represent thousands of families in Connecticut that are covered by insurance that our employers provide. And our business representatives and our employers are all constantly struggling with the insurance industry over denials of claims.

HB5303

Things that we think are obviously good claims, get turned down, get thrown into a bureaucratic struggle that our members are already sick have to suffer under. This bill would help throw a light on these kind of practices. We think it's a step in the right direction.

These companies make their money not by providing care but by denying claims. And the Machinists Union position is that the insurance industry should be nationalized. We think this is a good step in the right direction by showing a light of truth on their activities.

Their profits have doubled in the last year. They have -- they're -- they're premiums are

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skyrocketing right now. And it -- the chutzpah that it takes to do this in the light of the -- the extreme exposure that they're getting with an attempt nationwide to reform their activities is astonishing.

On top of that, we got to have a government that supports the idea of universal health care. And obviously the Insurance Commissioner of Connecticut whose backing up these outrageous claims of the insurance companies, in my mind he has to go.

And the last thing I'm going to say is I'm calling for the resignation of the Insurance Commissioner of Connecticut. Thank you.

SENATOR CRISCO: Thank you, Bill. Could you explain chutzpah? What's going on? No. I'm only kidding. I'm only kidding.

Questions of Bill? Bill?

Thanks for being with us today.

BILL SHORTELL: All right.

SENATOR CRISCO: Appreciate it.

BILL SHORTELL: Thank you.

SENATOR CRISCO: Karen.

KAREN SCHUESSLER: Hello. 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. And I strongly support H.B. 5303. It is important for insurance companies to disclose their denial rates for numerous

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reasons.

Consumers have a right to know when they're shopping for insurance the rate at which insurance companies deny claims. Only one state, California, releases denial rates. And unfortunately when it comes to claims denials, insurers may be putting profits ahead of patient's health.

According to a report by the Center -- Center for American Progress, three of the sixth largest health insurance companies in California each denied 30 percent or more of all claims filed in the first six months of 2009. And the California Nurses Association which disclosed the data says the high percentage of denials suggests that the insurers are going beyond reasonable standards to reject claims and may be using claims to boost profits.

And Wendell Potter, a former senior public relations executive at Cigna, he was working right here in Connecticut, resigned in 2008 to become a whistleblower and he stated that claims denials are probably the most effective way the industry has to manage medical expenses.

And the Los Angeles Times has reported that Health Net was exposed for awarding employee bonuses based on how many policies they had rescinded. Another tactic the insurance company's employees to cancel individual coverage once a person starts making expensive claims on the policy. And these claims trigger underwriting, which means they go back into your medical history and your completed application to find evidence of pre-existing conditions.

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And tragically there is a story reported in the Los Angeles Times in June of this year of a nurse who had her health insurance canceled when she developed cancer because they reviewed her medical history and said she did not disclose she had seen a dermatologist for acne.

Another tactic insurance companies can also deny claims by reassigning their medical directors, the doctor's who approve or deny claims for medical reasons to report to their business managers whose main responsibility is to boost profits. And up until a decade ago, they reported to the chief medical officer who had a final say on whether coverage was granted or denied.

Let me just wrap up here. And at a time when the country is suffering from the worst economic downturn since the Great Depression, filings with the US Security and Exchange Commission reveal that the five largest for profit health insurers, you know, had a combined profits of 12.2 billion in 2009 which is up 56 percent from the previous year.

But they also provided coverage to 2.7 fewer people. So, insurance companies have spent hundreds of millions of dollars lobbying -- on lobbying and campaign contributions trying to defeat health care reform. So if they have enough premium revenue to work to defeat reform, surely they have enough revenue to stop denying so many health claims.

And I urge you to support this bill and halt -- halt the injustice of insurance companies prospering as families and individuals continue to suffer through our broken health

care insurance system.

SENATOR CRISCO: Thank you, Karen.

Any questions?

Any questions?

No. Thank you very -- I'm sorry. Representative Altobello.

REP. ALTOBELLO: Thank you, Mr. Chairman.

I just briefly -- I believe you said someone resigned from an insurance company to become a whistleblower?

KAREN SCHUESSLER: Wendell Potter. He was here in November.

REP. ALTOBELLO: Is that -- is that a paid position somewhere? Or is that --

KAREN SCHUESSLER: What? A paid position? What's that? No. He's just spreading the word. He actually --

REP. ALTOBELLO: Okay. He retired but is not with another firm or something.

KAREN SCHUESSLER: He's -- there's no fee. You can get him -- he's not -- he's with the Center for Media and Democracy. He's sort of a fellow with them. But, he's making a lot less money with the insurance industry. But, it's -- it's --

REP. ALTOBELLO: So he's --

KAREN SCHUESSLER: -- he will come to speak for free. He's -- it's -- was that your question?

REP. ALTOBELLO: Thank you, Mr. Chairman. I was just curious. I didn't know. I thought it was a new profession. We're looking to create jobs here in Connecticut. You know, so --

REP. FONTANA: No. I think just for the record, I think Mr. Potter did leave Cigna and I think he's working with a --

KAREN SCHUESSLER: The Center for Media and Democracy, yes.

REP. FONTANA: Very good. Thank you.

SENATOR CRISCO: He was up in UCONN Law School some time ago or Hartford Campus.

KAREN SCHUESSLER: He was here too. He was actually here in Hartford.

SENATOR CRISCO: Any other questions?

Thank you very much.

KAREN SCHUESSLER: You're welcome.

SENATOR CRISCO: We'll sedge way into Bill 258 and it's a no, no number one. Susan.

SUSAN HALPIN: My reputation proceeds me, Senator. Good afternoon, Senator Crisco, Representative Fontana, Representative D'Amelio, distinguished members of the committee. For the record my name is Susan Halpin. And I'm here today on behalf of the Association -- Connecticut Association of Health Plans.

With respect to Senate Bill 258, you have my written testimony in front of you. But we would respectfully urge your rejection of this

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provider. As well as, in cases of behavioral health, medical notes that the treating physician may not want the member to see. The law requires us to do it for everybody. And it requires us to do it for not only the treating physician but also the enrollee.

So, thank you very much for your time. Any questions that you might add.

SENATOR CRISCO: Thank you, Christine.

Chairman Fontana.

REP. FONTANA: Thank, Mr., Chairman.

Thanks Christine.. On 5303, would you tag onto the end of your testimony?

CHRISTINE CAPPIELLO: Yes.

REP. FONTANA: You mentioned the HEDIS survey.

CHRISTINE CAPPIELLO: Yes. The HEDIS survey.

REP. FONTANA: Okay. I didn't know how to pronounce it. What is that survey? And who requires you to do that?

CHRISTINE CAPPIELLO: It's -- it's a -- it's a national survey that's done by our accreditation organization, NCQA, and it -- there's lots of different measurements within it. But, it's generally around health. So, it's how many patients -- how many of your members are identified that have cholesterol -- that are taking cholesterol medications? I think there's a beta blocker question in there.

And so, the Managed Care Survey mirrors pretty

much that HEDIS survey. So that, it's data we have to collect and produce any way. And so, we just use essentially the same information that we provide to our accrediting organization. We provide to the state. So we just ask that you keep that in mind.

So that we don't have to collect a whole new set of data and or kind of -- have to pull a whole new set of data out of our claims information. And I honestly don't -- it's not clear to me if HEDIS address specifically claims denial.

REP. FONTANA: Right.

CHRISTINE CAPPIELLO: So we need to get back to. But I just -- that's the only caviat that we have. And sometime HEDIS changes and we have to go through and change the survey. So.

REP. FONTANA: I guess I would just say to that end if you can provide us with copies of the HEDIS survey as it relates to claims denial information, we'd be happy to do it.

CHRISTINE CAPPIELLO: Sure.

REP. FONTANA: We can to try to comport with HEDIS to minimize the impact to you.

CHRISTINE CAPPIELLO: Thanks.

REP. FONTANA: It's conceivable that we would be interested in things that are not in HEDIS. So, there might be some additional work on your part. But to the extent that we can accommodate HEDIS reporting requirements, we'd be happy to do so. So, if you'll provide us with that, that'd be great.

CHRISTINE CAPPIELLO: Okay.

KEN FERRUCCI: Thank you.

Thank you, Mr. Chairman.

SENATOR CRISCO: Thank you.

Any other questions?

Thank you very much.

Proceed to Senate Bill 260. Susan Halpin.

SUSAN HALPIN: Good afternoon again, Mr. Chairman members of the committee. Susan Halpin for the record on behalf of the Connecticut Association of Health Plans. I'm here to testify in opposition to Senate Bill 260, AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR ROUTINE PATIENT CARE COSTS FOR CLINICAL TRIAL PATIENTS.

Many of you are aware of the work that we've done previously with the American Cancer Society. And a number of Connecticut Oncologists to cooperatively develop a model for coverage for routine costs of cancer clinical trials.

We're very proud of that work. We sat down over a period of twelve months to craft, for a single area of care in a process that all parties agreed that coverage for routine care expenses was the right thing to do. And that patient safety and sound medical research protocols were paramount to providing the meaningful health benefits for the dollar.

The most encouraging thing about that process was that there was no argument about the

refrain from driving up the costs for these small companies that are just trying to do the right thing. Thank you.

SENATOR CRISCO: Thank you, Eric.

Any -- any questions? Any questions?

Let me just comment. And I know I shouldn't. But, you know, instead of an insurance company making 3.4 billion maybe they should make 3 billion and not increase their rates.

Thank you very much.

ERIC GEORGE: I'm sure that should be relayed to the industry. I'm just representing the employers.

SENATOR CRISCO: I understand. Thank you.

I know you will.

Vicki.

VICTORIA VELTRI: Good afternoon, Senator Crisco, Representative Fontana, Representative D'Amelio and remaining members of the Insurance and Real Estate Committee. My name is Vicki Veltri and I am the General Counsel for the Office of Healthcare Advocate.

And I'm here to address a few bills so please turn the timer off. My first -- the first bill I want to testify in favor of is H.B. 5300. As you know this is a bill that Representative Rodan has already said that one of his constituents had approached him about this.

HB5303
SB258
SB260
HB5300

It's not -- it's really not easy to -- there's

no one easy answer to this problem. You know, the uninsured that -- that are below 250 percent of the federal poverty level, some of them are eligible for free care. That availability varies quite widely from hospital to hospital.

People who are above 250 percent of federal poverty and who are uninsured, are sort of left out. And they can get charged whatever -- whatever the hospital wants to charge them. So I think the true intent of this bill was to try to find a range where it's appropriate that people should get a break who are uninsured.

I mean we don't want millionaires coming and paying nothing. But we want people who work hard for their money, who can't get policies otherwise because they have pre-existing conditions or otherwise can't afford it. We want them to get a break.

And so that's really what that bill's about. And I'm happy to work with Representative Roldan and anyone else on further language for this bill. So that's that bill.

5303 seems to be to me -- is common sense. It's an extension of transparency. Insurers are in possession of this data. It shouldn't be very hard at all for them to produce it. And if they want the business of the people of Connecticut, they should come up with it. So they can show the cost. Show the rates of denial.

With what we're getting now is just a partial picture in the report card. So, we -- we've wanted an extension of that data reporting. And we want the reporting to be specifically

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M. Katz
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State Medical Society

160 St. Ronan Street New Haven, CT 06511-2390 (203)

Connecticut State Medical Society Testimony
SB 258 An Act Concerning Appeals of Health Insurance Benefits Denials
HB 5303 An Act Requiring Reporting of Certain Health Insurance Claims Data
Insurance and Real Estate Committee
March 4, 2010

Senator Crisco, Representative Fontana and members of the Insurance and Real Estate Committee, on behalf of the more than 7,000 members of the Connecticut State Medical Society (CSMS) thank you for the opportunity to present this testimony to you today in support of SB 258 An Act Concerning Appeals of Health Insurance Benefits Denials and HB 5303 An Act Requiring Reporting of Certain Health Insurance Claims Data. Together, these bills make significant strides forward to strengthen the insurance claims denial statutes while adding transparency to the process through increased data reporting by managed care organizations (MCOs) and related entities.

The most critical aspect of language contained in SB 258 An Act Concerning Appeals of Health Benefits Denials is the presumption included within that an admission, service, procedure or extension of stay being appealed is medically necessary. This appropriately places the burden on theMCO to prove that the admission, service, procedure or extension of stay properly ordered by a licensed participating provider is not medically necessary. This provision acknowledges the sanctity of the physician/patient relationship when determining appropriate medical care.

The draft bill also contains language that will require a clear statement by the MCO to both the enrollee and provider of all documents and information used in a final determination not to certify services. Complete and accurate information is vital to physicians and enrollees (patients) when deciding whether or not to appeal a determination made by a MCO. Subsequently, the bill requires appealed prescriptions to be filled pending the outcome of the appeal and final determination to be communicated within five business days. CSMS supports these requirements.

CSMS does request that an important amendment be made to the proposed language. The bill could be strengthened for patients and physicians by allowing for the filing of multiple denials under the same claim with one twenty five dollar fee. We see no reason to require separate filings, provided the denials are for identical services and diagnostic codes, with the same insurer and have an expected identical outcome.

CSMS also respectfully asks for you support of HB 5303 An Act Requiring Reporting of Certain Health Insurance Claims Denial Data. However, we also ask the committee for what we consider a minor clarification to the bill. The underlying bill requires MCOs to including in their annual reporting to the Insurance Department (CID) comprehensive information regarding claims denial data. As recently as this week, the *Hartford Courant* reported a significant increase in the denial of health insurance claims. To fully understand the increase in this denial trend, transparency is necessary and pertinent information should be provided to CID and

subsequently reported publicly through the Consumer Report Card as well as posted on the CID website.

We do ask for an amendment to current language. Section 1(a) 6 requires the reported information to included (C) the total number of denials that were appealed. Language should be changed to include the number of claims "Partially Denied." Physicians often provide services that require multiple codes be submitted for approval and payment. Often, only a portion of the claim is approved and paid. This information should also be captured.

Thank you for the opportunity to provide this testimony to you today. Please Support SB 258 and HB 5303.

001396

Anthem Blue Cross and Blue Shield
370 Bassett Road
North Haven, Connecticut 06473-4201
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March 4, 2010

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LINE 14

**Statement
Of
Anthem Blue Cross and Blue Shield
On
SB 258 An Act Concerning Appeals of Health Insurance Benefit Denials
And
HB 5303 An Act Requiring Reporting of Certain Health Insurance Claims Denial Data**

Good afternoon Senator Crisco, Representative Fontana and members of the Insurance and Real Estate Committee, my name is Christine Cappiello and I am the Director of Government Relations for Anthem Blue Cross and Blue Shield in CT. I am here to testify against SB 258 An Act Concerning Appeals of Health Insurance Benefit Denials and HB 5303 An Act Requiring Reporting of Certain Health Insurance Claims Denial Data.

To begin, in regards to SB 258, we are unsure why this legislation is before you today. The utilization review statutes that were passed in 1997 and modified over the years have produced a process that allows for a fair and reasonable appeal process for the member, the treating provider and the insurer. This legislation upsets the delicate balance that over the years that this law has been in place.

Almost every section of this bill purports to take the current utilization process and turn it on its head and sets a standard where insurers would be left to approve and pay for any service that is requested because the administrative burden and inability to manage utilization will leave the carriers no other choice. One of the best examples of this is the proposed change to the definition of medical necessity to say the burden of proof to prove the service requested is not medically necessary. While on the face of it, this may seem like a consumer friendly notion, because of the short time frame that we have to make a decision on whether something is medically necessary we would rely on the requesting physician to provide the information to make the decision, but there is nothing to compel them to and we would left to approve a request because we could not meet the burden of proof standard for denying coverage. I have reached out to our Medical Directors to give some real life requests for coverage that, under this new burden of proof standard, we could be compelled to cover:

- Obesity surgery for people with body mass index under 25 (i.e. normal weight)
- Power wheelchair (usually around $10,000) for a person with a sprained ankle
- Coverage for a bicycle to travel to work
- Coverage for hot tubs
- 7 days inpatient stay requested so family could go camping
- Frequent requests for cosmetic procedures said to be medically necessary

Another great example of the unnecessary administrative burden that arises in this bill is the notion throughout the bill that we have to provide the provider or enrollee all the information, including what they have sent to us, that we used to make the decision. The real life implication of this concept is that we would be required by law to send back reams of medical records and doctors notes that were sent to us for a request for coverage. It doesn't seem to make any sense to have to mandate that in every case we send back to the provider the records they sent us to say nothing of the fact that we would be

In Connecticut, Anthem Blue Cross and Blue Shield is a trade name of Anthem Health Plans, Inc. an independent licensee of the Blue Cross and Blue Shield Association. ® Registered marks of the Blue Cross and Blue Shield Association.

required by law to send a provider confidential medical notes back to his/her patient, that the provider most likely does not want to share with them particularly in cases of mental health services.

We continue to ask ourselves, what is the goal of this legislation except to increase administrative costs and cause the insurer to contemplate even doing any utilization management at all, which is one of the fundamental reasons employers involve us in administering health benefits.

We want to leave the committee with this very important thought: The Legislature worked very hard to align the utilization process found in 38a-478n with federal Department of Labor regulations and have sensible criteria to govern the UR and appeal processes for Connecticut's citizens and this legislation will simply unravel that hard work and do nothing but add costs to the healthcare. We strongly urge the committee to reject SB 258 An Act Concerning Appeals of Health Insurance Benefit Denials

In regards to HB 5303, as the Committee is aware, we produce a substantial amount of information for the benefit of consumers in the Annual Managed Care Report Card. We are unsure of the value of this information to consumers and question whether this annual report contains too much information for consumers to digest. In addition, we ask that the Committee consider aligning this new information that we are being asked to report to be aligned with what we must report for the annual HEDIS survey so that the data is consistent.

Thank you for your attention to this matter and we welcome any questions you may have.

5303
FTR

Quality is Our Bottom Line

Insurance Committee Public Hearing
Thursday, March 4, 2010

Connecticut Association of Health Plans

Testimony regarding

HB 5303 AA Requiring Reporting of Certain Health Insurance Claims Denial Data.

The Connecticut Association of Health Plans would be pleased to engage in a continuing dialogue around reporting claims denial data. Toward that end, we would appreciate the opportunity to work with the Committee and the Department of Insurance in determining what measures would prove meaningful to industry regulators and the public at-large.

Thank you for the opportunity to provide comment.

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5303 FTR

SMALL BUSINESSES FOR HEALTH CARE REFORM

March 3, 2010
Testimony to the Insurance and Real Estate Committee, Connecticut General Assembly

H.B. 5303: AN ACT REQUIRING REPORTING OF CERTAIN HEALTH INSURANCE CLAIMS DENIAL DATA

I'm Kevin Galvin, owner of Connecticut Commercial Maintenance, a small business located in Hartford. I am also Chair of Small Businesses for Health Care Reform. I have been a small business owner since 1976 when I parlayed my experience as a motor sports competitor into a motor sports promotion business in the U.S. and six other countries. In 1985 I founded Colonial Handyman, which has grown into Connecticut Commercial Maintenance (CCM) a commercial and residential full-service repair, maintenance and facilities consulting company with a diverse client base that ranges from local homeowners to national retailers with Connecticut sites to nonprofit organizations. My company has had as many as ten employees.

The mission of Small Businesses for Health Care Reform (SBHCR) is to make sure Connecticut small businesses have access to quality, affordable health care options. SBHCR provides a voice for small business reflecting our interest in health care policy and the realities of operating a business.

When I served as President of the West Hartford Chamber of Commerce, I worked to expand opportunities, including health insurance options for small employers. Small businesses are very different in a lot of ways, but they have a lot in common:

- Most have thin profit margins – not a lot of extra money to spend
- They don't have a lot of time to research things like health insurance plans
- They need their employees to be productive and as healthy as possible

I know how hard it is to run a small business. The odds are against you – most small businesses fail in their first five years. And obtaining and affording health insurance for the business owners and the employees is almost impossible. Fewer than half of small businesses can afford to provide health insurance to their employees.

(860) 523-1028
info@smallbusinessesforhealthcarereform.org smallbusinessesforhealthcarereform.org

But as a small business owner, every dime I spend comes from my bottom line, from my pocket. So I am very, very careful about how I spend my money. I know my vendors personally. I only deal with companies that give me good value. Most other small business owners operate the same way. We ask our vendors a lot of questions to make sure we are getting the best deal possible and that the products we purchase will serve us now and in the future.

So that brings me to insurance. I have done a lot of research about purchasing health insurance. And when I start comparing one policy to another, I ask various questions:

- How much will this policy cost?
- What are the factors that affect this cost?
- What services does this policy cover?

But when I ask if the insurance company will cover my employees' claims, they can't tell me. They can't give me enough information to make a sound decision. Currently insurance companies are not required to disclose the number or amount of the medical claims they deny, or the reasons for the denials.

I have personal experience with claim denials. My health insurance company denied a family member's claims to the detriment of her health. The problem was not solved until the Office of the Health Care Advocate became involved. Right when you should be focused on helping your family member get well, you are fighting with the insurance company to honor its obligations. That is not an experience I want to go through again. I want to deal with companies that honor their obligations. But I need to know which companies have the fewest denials, and pay the most claims.

My other vendors tell me if they will come through for me and my business.

I need to know that my health insurance company will do the same.

I want insurance companies to disclose the details of claim denials, so I and my fellow small business owners can make educated choices about which plans to purchase. We need to know that we are purchasing a plan that will cover our employees even if they become sick, even if they actually need the insurance. I support HB 5303, and commend the sponsors of the bill for standing up for the citizens of Connecticut.

001435

5303

National Association of Social Workers / Connecticut Chapter

2139 Silas Deane Highway
Suite 205
Rocky Hill, CT 06067
(860) 257-8066

Sherry Ostrout, MSW, CMC, President
Stephen A Karp, MSW, Executive Director
naswct@conversent.net

PAGE 6
LINE 1

Testimony on House Bill 5303
An Act Requiring Reporting of Certain Health Insurance Claims Denial
Insurance Committee – March 4, 2010
Submitted By: Stephen A. Karp, MSW

On behalf of the National Association of Social Workers, CT Chapter, representing over 3400 members we support House Bill 5303. This bill will spread light for consumers and employers on the rate of denials of claims per managed care organization.

The Office of Health Care Advocate has tracked the number of complaints brought to their office based on the nature of complaints. Since 2006 each year the largest number of complaints has been Denied Service/Treatment. In 2006 and 2007 the number of such complaints respectively was 286 and 274. In 2008 that number of complaints was 232, but in 2009 it dramatically rose to 510, an over 50% increase in one year! This may be due to an increase awareness of the Health Care Advocate's office or insurers seeking greater profitability, but either way it speaks to the importance of having claims denial information made public in a way that allows for tracking trends and informing purchasers of health insurance.

As an association that represents social workers, including clinical social workers, one of the most common complaints that we receive regarding managed care organizations is denial of initial treatment, or denial for continued treatment. This corresponds with additional data of The Office of Health Care Advocate that shows that mental health is consistently, each year, the category with the highest frequency of complaints. Again, HB 5303 will shed valuable light and information on the level and prevalence of denials of care.

In reviewing the bill's provisions we recommend to the Insurance Committee that the bill language be modified to require that MCOs report mental health data separately per each category. The reason for this is that complaints related to mental health have the greatest frequency, as noted above, and over the years have led to disputes between MCOs and mental health providers as to the question of whether mental health care is given true parity by insurers. For example, one major MCO has a long record of denying the necessary level of care for eating disorders, despite the fact that such a disorder often becomes life threatening. Reporting mental health data separately will go a long way to addressing the issue of parity. This recommended change in language also has precedent in the current statute (Section 38a-478l of the general statutes) whereby the consumer report card includes information on mental health as a separate category.

HB 5303 will build greater transparency and provide valuable information that allows consumers and employers to be well educated and better informed as they purchase health care insurance. We urge passage of this bill.

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PAGE 6
LINE 9

Jamie Mott Testimony for (H.B 5303)

My name is Jamie Mott. I am 32 years old and I have a chronic repetitive strain injury called myofascial pain syndrome. My condition is a work-related injury that I got at 21 while using the computer extensively in college. Since then the injury has become progressively worse as I have continued to try to work and so I've been in unrelenting pain for the last 11 years. Because my injury happened at college instead of at a job, I wasn't eligible to get workers compensation benefits so I have been unlucky to be fully reliant on health insurance for medical support for my condition. The reason I wanted to come here to speak today is to tell you of my horror and heartbreak. I hope that that together we can put legislation in place that will protect the sick and injured as well as healthy consumers of health insurance. This bill would prevent consumers from wasting their time and their money while giving them the tools to advocate for their care and their health.

If I had a dollar for every minute wasted dealing with health insurance red tape I would be as rich as an Insurance Company CEO. I am a certified ESL teacher but because of the physical demands of the profession I am unable to do what I went to school to do. I instead work part time as a tutor or a substitute teacher. These professions however almost never provided health insurance. Previous to this year I was living in California where some companies allow us to extend cobra. It was very expensive with high deductibles and didn't cover the treatment I needed for my condition. So I lived at my parent's house in order to pay for insurance and out-of-pocket medical costs which totaled about 70% of my income. I looked into individual plans that were less expensive than cobra but I was denied from multiple companies for having a pre-existing condition. It was a complete waste of my time and was extremely humiliating and made me feel very angry, helpless and hopeless. It was also very scary when I moved to Connecticut and went without insurance when I learned that I could not carry my cobra out of state. If legislation passed that required insurance companies to disclose their denial claims for coverage at least people like me would know from which companies we even stood a chance at buying insurance.

As I mentioned earlier I have poured countless dollars into paying for uncovered out-of-pocket medical costs. I have chronic problems with my muscles and tendons. The only therapy that helps me is trigger point muscle therapy and chiropractic treatment which I have always paid out of pocket for because I can't seem to get insurance to pay for it even though it is medically necessary. So what I have had to do was desperately search for advocating doctors that know the ins and outs of the politics of insurance. This kind of doctor is almost impossible to find. It has been like a needle in a haystack. It's very frustrating for me because I don't feel like I should be choosing my doctor based on their knowledge of the insurance business or waste my time with my doctor talking about insurance politics. If information about medical claim denials was mandated to be disclosed then I wouldn't waste all my time and money going through fruitless medical loops and instead choose medical insurance based on their rate of denials or approvals for treatment that I need. I've been waiting for 11 years to find an insurance company that will actually pay for something that actually helps my condition. Isn't that too long to wait?

In conclusion, when I think about my experience with the health-insurance industry the idiom that best describes it is "adding insult to injury." I really hope that we can work together to provide some hope for the many Americans who have to fight a constant uphill battle just to get the medical support they deserve to get well and feel better.

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Testimony on Raised H.B. No. 5303
AN ACT REQUIRING REPORTING OF CERTAIN HEALTH INSURANCE CLAIMS DENIAL DATA
Insurance and Real Estate Committee
March 4, 2010

My name is Brian Anderson and I am the Legislative & Political Representative from Council 4 AFSCME. Council 4 represents approximately 35,000 state, municipal and private contract public service workers statewide.

We strongly support House Bill 5303: An Act Requiring Reporting of Certain Health Insurance Claims Denial Data. There are a number of reasons it is important to know the rate at which insurance companies deny medical claims. Aside from increasing the amount of transparency in the industry, it has the potential to foster a great deal of accountability to consumers. Additionally, publishing the denial data in the Consumer Report Card will allow unions, businesses, and individuals seeking health insurance make an informed decision about which company they should seek coverage from.

Currently, insurance companies have every incentive to deny medical claims. When a claim is denied, that is money they are saving for their for-profit corporation. Money not paid out in claims is money that can be used to pad more profits. Since we have no idea how endemic this practice may be in Connecticut, insurance companies have the ability to deny claims without any fear. Having this information available to the public and the news media would serve as a powerful corrective measure. If the process becomes more transparent, insurers may not be able to frivolously deny as many claims as they have in the past, which is a win for consumers. And as I'm sure the industry will say that they do not deny claims frivolously and that there is a good justification for each denial, then there should be no concern about publishing this data.

The other anticipated benefit from passing this bill is the assistance it will provide every individual and business in our state when they are trying to determine which health insurance company should be their insurer. There are obviously other important factors to take into consideration when choosing your health insurance such as cost, the size of the in-network doctors and hospitals, among other things. What none of that other information is able to glean, though, is how often claims are denied. If I am reviewing two comparable health care plans, then this sort of information will help inform me about which to choose.

I urge you to support this bill in order to promote transparency and accountability in the industry while perhaps more importantly helping individuals and our business community find health care that is right for them. This is a win-win scenario for anyone that ever has to look for health insurance.

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LINE 11

Testimony of the
~~Connecticut ENT Society~~
Connecticut Urology Society
Connecticut Orthopaedic Society
Connecticut Society of Eye Physicians
Connecticut State Society of Anesthesiology
Connecticut Chapter of the American College of Surgeons
Connecticut Chapter of The American College of Cardiology
Connecticut Dermatology and Dermatologic Surgery Society

On HB 5303, An Act Requiring Reporting of Certain Health Insurance Claims Denial Data.

Before the Insurance and Real Estate Committee
On
March 4, 2010

Good Afternoon, Senator Crisco, Representative Fontana and other distinguished members of the Insurance and Real Estate Committee, for the record my name is Dr. Bill Ehlers and I am a board certified ophthalmologist practicing at UCONN medical center. I am also the legislative chair of the Connecticut Society of Eye Physicians and am here to represent over 2500 physicians in the medical fields of Ophthalmology, Otolaryngology, Dermatology, Orthopaedics, Anesthesiology, Cardiology,General Surgery and Urology to support HB 5303.

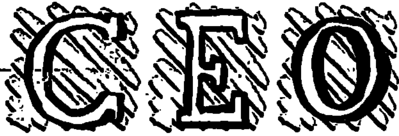
First, I would like to thank this committee for raising this important consumer advocacy bill, which looks to strengthen and continue the transparency movement this committee has long supported with regard to healthcare. As many of you know, physicians have been seeking better information on where the healthcare dollars are being spent and we agree that it is also important to report on services that are being denied coverage in Connecticut. HB 5303 takes bold steps to make this information transparent to both consumers and providers. We do believe, however that some simple amendments will go a long way toward strengthening the bill, improving full disclosure and creating the kind of transparency that will make the consumer report card a valuable consumer tool.. Medical claims often include multiple services and diagnoses on one claim. A patient may come in to have their eye pressure monitored for glaucoma and in the course of the examination is found to have a suspicious lesion on the eye lid, which is removed and sent to a lab for pathology, rather than have the patient return days later to have the procedure done. The physician bills for the glaucoma examination with a glaucoma diagnosis, and he bills for the surgical procedure using procedure and diagnosis codes specific to the removal of the suspicious lesion, all on the same claim form. Many times the Managed Care Organization will not deny the whole claim but will deny part of the claim- either the code for the exam or the code for the procedure.

We believe if we amend the language in lines 82 and 83 we can better capture these types of denials of services or procedures. The language we are suggesting is-

82 numbers of claims denied; **including claims that have multiple procedures or services where at least one service or procedure is denied coverage on the claim**(C) the total number of denials that were
83 appealed; **or partially appealed** (D) the total number of denials that were reversed upon
84 appeal; (E) (i) the **specific** reasons for the denials, including, but not limited to,
85 "not a covered benefit", "not medically necessary" **"experimental"** and "not an eligible
86 enrollee", (ii) the total number of times each reason was used, and (iii)
87 the percentage of the total number of denials each reason was used;
88 and (F) other information the commissioner deems necessary.

Additionally we would like the word specific added to line 84 and experimental added to the reasons for denial. Providers are often perplexed to see a prescribed and acceptable form of treatment get denied with an explanation from the managed care company listing "experimental" as the reason for the denial on the explanation of benefits.

In closing, we would like to support this important piece of legislation for consumers and hope that you will consider the language we offered to help address some of the issues providers are seeing when it comes to the denial of care by the industry.



5303

CITIZENS FOR ECONOMIC OPPORTUNITY
Corporate Responsibility Campaign

PAGE 6
LINE 15

H.B. 5303 - An Act Requiring Reporting of Certain Health Insurance Claims Denial Data

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

I strongly support H.B. 5303. It is important for insurance companies to disclose their denial rates for numerous reasons. Consumers have a right to know when shopping for insurance the rate at which insurance companies deny claims yet only one state, California, releases denial rates. Unfortunately, when it comes to claims denials, insurers may be putting profits ahead of patient's health.

According to a report by the Center for American Progress, three of the six largest health insurance companies in California each denied 30 percent or more of all claims filed in the first 6 months of 2009. The California Nurses Association which disclosed the data says the high percentage of denials suggests that the insurers are going beyond reasonable standards to reject claims and may be using claims to boost profits. Wendell Potter, a former senior public relations executive at Cigna who resigned in 2008 to become a whistleblower states that "Claims denials are probably the most effective way the industry has to manage medical expenses." The *Los Angeles Times* has reported that HealthNet was exposed for awarding employee bonuses based on how many policies they had rescinded. In addition, critics claim that insurers intentionally use confusing applications so that when a member begins filing claims, the insurer can go back and find mistakes in the application to justify a rescission.

Another tactic the insurance companies employ is to cancel individual coverage once a person starts making expensive claims on the policy. Such claims trigger post claims underwriting which means they investigate a policyholders already completed application and medical history to find evidence of pre-existing conditions. Tragically, there is the story reported in the *Los Angeles Times* in June, 2009 of a nurse who had her health insurance cancelled when she developed cancer because they reviewed her medical history and said she did not disclose she had seen a dermatologist for acne.

Insurance companies also deny claims by reassigning their medical directors (the doctors who approve or deny claims for medical reasons), to report to their business managers whose main responsibility is to boost profits. Up until a decade ago they reported to the chief medical officer who had final say on whether coverage was granted or denied based on medical criteria.

Data from The American Medical Association's "National Health Insurer Report Cards," report that the percentage of claims denied only shows a portion of the claims denied. The numbers are actually higher because these percentages include only instances in which entire claims were denied for reasons such as the individual wasn't actually covered by the company or the claim had been improperly filled out.

These numbers do not include instances where companies denied select treatment and procedures rather than the entire claim.

At a time when the country is suffering from the worst economic downturn since the Great Depression, filings with the U.S. Securities and Exchange Commission reveal that the five largest for-profit health insurers, UnitedHealth Group, WellPoint, Aetna, Humana and Cigna enjoyed combined profits of $12.2 billion in 2009, up 56 percent from the previous year. However, these companies provided insurance coverage to 2.7 million fewer people than the year before.

Insurance companies have spent hundreds of millions of dollars on lobbying and campaign contributions trying to defeat health care reform so if they have enough premium revenue to work to defeat reform surely they have enough revenue to stop denying so many health claims. I urge you to support this bill and halt the injustice of insurance companies prospering as families and individuals continue to suffer through our broken health insurance system.

Karen Schuessler
Director
Citizens for Economic Opportunity
860-674-0143

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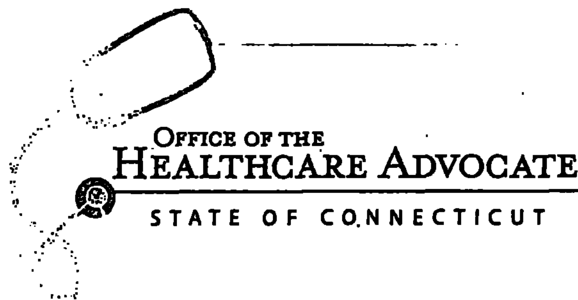

PAGE 11
LINE 1

Testimony of Victoria Veltri
General Counsel

Before the Insurance and Real Estate Committee
In support of HB 5303, SB 258 and SB 260
March 4, 2010

Good morning, Senator Crisco, Representative Fontana, Senator Caligiuri, Representative D'Amelio and members of the Insurance and Real Estate Committee. For the record, I am Vicki Veltri, General Counsel with the Office Healthcare Advocate ("OHA"). 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.

OHA supports HB 5303, AN ACT REQUIRING REPORTING OF CERTAIN HEALTH INSURANCE CLAIMS DENIAL DATA. These reporting requirements are necessary to provide a fuller picture of the number of all types of denials. This is critical to gauging the rate of all denials by the insurers. The inclusion of this information on the consumer report card and on the Insurance Department's website is an important move toward optimal transparency. Capturing all denials provides a truer picture of the marketplace.

OHA offers two suggestions that we think are necessary for the bill to achieve its goal:

A. While it is clear in the Insurance Department's requests to insurers for report card data, the bill would be clearer if it included a definition for "denial" or referenced the fact that denials include "partial denials". It must be clear that every instance of the word "denial" in the bill is meant to include "partial denials."

B. Although section 1(a)(6)(E) states that the types of denials to be reported are not limited to those listed, the committee could improve this subsection by including "experimental and/or investigational" as one of the denial types required.

Transparency in healthcare pricing is inevitable. We suggest that the practice of posting the pricemaster referred to in HB 5003 begin with the top 30 procedure codes used at each hospital so that consumers can start comparing costs and quality of care.

Thank you for allowing me to testify today. If you have any questions, you may contact me at victoria.veltri@ct.gov or 860-297-3982.

S – 600

CONNECTICUT
GENERAL ASSEMBLY
SENATE

PROCEEDINGS
2010

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PART 3
618 – 932

Without objection, so ordered.

THE CHAIR:

Thank you, Mr. President.

Calendar 416 is PR; Calendar 417, House Bill Number 5282, Mr. President, move to refer this item to the Committee on Public Safety and Security.

THE CHAIR:

Seeing no objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

Calendar 418, PR; Calendar 419, House Bill Number 5303, Mr. President, I move to place this item on the consent calendar.

THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

Moving to calendar page 32, Calendar 420 is PR; and Calendar 421, House Bill Number 5388, Mr. President, move to place that item on the consent calendar.

THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

S – 601

CONNECTICUT
GENERAL ASSEMBLY
SENATE

PROCEEDINGS
2010

VOL. 53
PART 4
933 – 1266

Bill 5265; Calendar 313, substitute for House Bill 5002.

Calendar page 20, Calendar 314, House Bill 5201.

Calendar page 24, Calendar 340, substitute for Senate Bill 175.

Calendar page 25, Calendar 346, substitute for Senate Bill 151; Calendar 350, Senate Bill 333; Calendar 371, substitute for House Bill 5014.

Calendar page 26, Calendar 375, House Bill 5320.

Calendar page 27, Calendar 379, substitute for House Bill 5278; Calendar 380, substitute for House Bill 5452; Calendar 381, substitute for House Bill 5006; Calendar 382, House Bill 5157.

Calendar page 28, Calendar 384, substitute for House Bill 5204.

Calendar page 29, Calendar 395, substitute for Senate Bill 127; Calendar 396, Senate Bill 147.

Calendar page 30, Calendar 413, House Bill 5024; Calendar 414, substitute for House Bill 5401.

Calendar page 31, Calendar 419, substitute for House Bill 5303.

Calendar 32 -- page 32, Calendar Number 421, substitute for House Bill 5388; and on calendar page 34, Calendar 46, substitute for Senate Bill 68;

Calendar 50, substitute for Senate Bill 17.

Calendar page 35, Calendar 64, substitute for Senate Bill 187.

Calendar page 37, Calendar 109, substitute for Senate Bill 189.

Calendar page 39, Calendar Number 148, substitute for Senate Bill 226.

Calendar page 40, Calendar 182, substitute for Senate Bill 218.

Calendar page 41, Calendar 188, substitute for Senate Bill 200.

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

THE CHAIR:

All right. If the Clerk has made an announcement that a roll call vote is in progress in the Senate on the first consent calendar, the machine will be open. Senators may cast their vote.

THE CLERK:

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

THE CHAIR:

Would all Senators please check the roll call board to make certain that your vote is properly recorded. If all Senators have voted and if all votes are properly recorded, the machine will be locked, and the Clerk may take a tally.

THE CLERK:

Motion is on adoption of Consent Calendar Number 1.

Total Number Voting 35

Those voting Yea 35

Those voting Nay 0

Those absent and not voting 1

THE CHAIR:

Consent Calendar Number 1 is passed.

Are there any announcements or points of personal privilege? Are there any announcements or points of personal privilege?

Senator LeBeau.

SENATOR LEBEAU:

Thank you, Mr. President, for a -- for an announcement.

THE CHAIR:

Please proceed.