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Dame and I'm trying to explain to him that's the school people go to who couldn't get into Villanova, but he won't fall for that.

But he is, I met him when he was an Eagle Scout, so he's a man of fine character and it's going to be our pleasure to have him working with us this summer, and that's Joseph Massa. I'd ask my colleagues to join me in welcoming him here. Thank you, sir.

SPEAKER DONOVAN:

Welcome, Joseph. See you around. Thank you. Representative Willis? All right, that's it. Thank you, everyone.

And we'll return to the Call of the Calendar. The Clerk please call Calendar 582.

THE CLERK:

State of Connecticut House of Representatives Calendar for Wednesday, June 8, 2011.

On Page 27, Calendar 582, Substitute for Senate Bill Number 18 AN ACT CONCERNING APPEALS OF HEALTH INSURANCE BENEFITS DENIALS. Favorable Report of the Committee on Insurance and Real Estate.

SPEAKER DONOVAN:

Representative Schofield.

REP. SCNOFIELD (16th):

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

SPEAKER DONOVAN:

The question is on acceptance of the Joint Committee's Favorable Report and passage of the Bill. Will you remark?

REP. SCHOFIELD (16th):

Thank you, Mr. Speaker. The Clerk has an Amendment, LCO 8629. I ask that the Clerk call the Amendment and I be allowed to summarize.

SPEAKER DONOVAN:

Will the Clerk please call LCO 8629, which was previously designated Senate "A". No, it will be designated House Amendment Schedule "A".

THE CLERK:

LCO Number 8629, House "A", offered by Representative Schofield.

SPEAKER DONOVAN:

The Representative seeks leave of the Chamber to summarize. Any objection? Hearing none, Representative, you may proceed with summarization.

REP.SCHOFIELD (16th):

Thank you, Mr. Speaker. The Amendment strikes the entire Bill and instead provides new language just to clarify a Bill that we passed earlier, that was Senate Bill 10.

The new language says that the coverage of MRIs for breast cancer screening must be covered by insurance plans, but only in accordance with national guidelines that are set by the American College of Radiology or the National Cancer Society. These guidelines are more circumscribed and give better protection to women by making sure that only those who really need them are subjected to this invasive procedure.

Thank you. I move adoption.

SPEAKER DONOVAN:

The question is on adoption. Will you remark further? Will you remark further? Representative Sawyer.

REP. SAWYER (55th):

Thank you, Mr. Speaker, and I would like to thank Representative Schofield for the thoroughness, because bringing this back and making that fairly technical but straightforward change empowers the rest of the Bill for the strength of the language that we know

that across the country is important because it should be similar as we go through the different states.

Thank you, Mr. Speaker.

SPEAKER DONOVAN:

Thank you, Representative. Representative Alberts.

REP. ALBERTS (50th):

Thank you, Mr. Speaker. If I may, a couple questions to the proponent.

SPEAKER DONOVAN:

Please proceed, sir.

REP. ALBERTS (50th):

Thank you, Mr. Speaker. In line 43 of the Amendment there's the word comprehensive, and I'm wondering how that inclusion of that word changes the context in terms of what we're looking at doing.

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Schofield.

REP. SCHOFIELD (16th):

It doesn't change it at all. If you look at line 17, Representative Alberts, through you, Mr. Speaker, you'll see the word was there. So it's just moving the word.

SPEAKER DONOVAN:

Representative Alberts.

REP. ALBERTS (50th):

Thank you, Mr. Speaker. And there are several references to the guidelines established by the American Cancer Society or the American College of Radiology and I would presume that these are the two standard industry guidelines or two standard healthcare guidelines that we should be looking at? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Schofield.

REP. SCHOFIELD (16th):

Yes, that's correct. These are organizations of physicians, medical experts in these particular areas and they establish the national best practices guidelines for all practitioners in the country.

SPEAKER DONOVAN:

Representative Alberts.

REP. ALBERTS (50th):

Thank you, Mr. Speaker. That's my understanding as well. Thank you.

SPEAKER DONOVAN:

Representative Carter.

REP. CARTER (2nd):

Thank you very much, Mr. Speaker. One question, through you, to the proponent of the Amendment.

SPEAKER DONOVAN:

Please proceed.

REP. CARTER (2nd):

Thank you, Mr. Speaker. I notice here we're talking about the guidelines of the American Cancer Society or the American College of Radiology. Are those guidelines similar? Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Schofield.

REP. SCHOFIELD (16th):

Yes. They're virtually identical. The American College of Radiology is slightly more detailed but they really say the same thing. Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Carter.

REP. CARTER (2nd):

Thank you, Mr. Speaker. As I understand it, then, we have two groups of established physicians that are recommending these guidelines, and I also

understand that this Amendment clarifies what happened yesterday.

Many people look at yesterday's Bill as a huge mandate. I think this corrects a lot of that and puts it in perspective.

Now, I'm going to say I'm in strong support of this Amendment because at the present time my own mother had her diagnosis of breast cancer just a few months ago. She finishes her first round of chemo in a couple of days. So I've got to tell you, I'm all for doing whatever we can to uncover breast cancer as early as possible and make as many survivors as possible, so I'm in strong support of this Amendment. Thank you, Mr. Speaker.

SPEAKER DONOVAN:

Thank you, Representative. Representative Coutu.

REP. COUTU (47th):

Thank you, Mr. Speaker. Mr. Speaker, I rise with strong support with the modification of the original Bill. I think it improves it drastically and is workable.

Thank you, Mr. Speaker.

SPEAKER DONOVAN:

Thank you, Representative. Representative Noujaim.

REP. NOUJAIM (74th):

Thank you, Mr. Speaker. Through you, Mr. Speaker, I do have one simple question to Representative Schofield.

SPEAKER DONOVAN:

Please proceed, sir.

REP. NOUJAIM (74th):

Thank you, Mr. Speaker, to Representative Schofield. I understand that this Bill came before us yesterday and I am very thankful that it came back for corrections.

Through you, Mr. Speaker, I would like to ask Representative Schofield what is the difference between the Bill that was presented yesterday and this Amendment?

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Schofield.

REP. SCHOFIELD (16th):

Thank you, Mr. Speaker. The Bill yesterday required overage of MRIs for all women who have dense breast tissue. That actually goes far beyond what all

of the clinical experts recommend. They actually recommend against doing that because it is an expensive and invasive procedure and it results in a lot of false positives, which then go on for women to have biopsies, which can be quite painful and have adverse outcomes for them, all for nothing because it's a false positive.

So they recommend that we only do these tests on women who are at high risk and those high risk indicators are what are included in the guidelines. So it's women who have what are called brack two gene mutations, family history, certain symptoms, et cetera, so that it's a much more targeted use of this procedure rather than using it on an enormous percentage of women who have dense breast tissue.

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Noujaim.

REP. NOUJAIM (74th):

Thank you, Mr. Speaker, and through you, Mr. Speaker, again, to Representative Schofield. I just received this Amendment now and I'm just going through, I'm just trying to read through it.

So it is my understanding then that yesterday's Bill was more demanding or more of a mandate. Now this one is restricting the mammograms to age or to heredity or to history in the family. And if I am correct through this, I would appreciate an explanation. Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Schofield.

REP. SCHOFIELD (16th):

Through you, Mr. Speaker, yes, that's correct, Representative Noujaim. It's more circumscribed, so it's less of a mandate.

SPEAKER DONOVAN:

Representative Noujaim.

REP. NOUJAIM (74th):

Thank you, Mr. Speaker. I truly, truly appreciate the answer and I intend to support this Bill and I am glad to see that it came back to the General Assembly to make it better. Thank you, Mr. Speaker.

SPEAKER DONOVAN:

Thank you, Representative. Representative Hetherington.

REP. HETHERINGTON (125th):

Thank you, Mr. Speaker. Actually, I think the response to Representative Noujaim pretty much covered what I wanted to ask, so I'll just say I stand in strong support of this Bill and I would urge its passage.

Thank you, Mr. Speaker.

SPEAKER DONOVAN:

Thank you, Representative. Representative Hovey.

REP. HOVEY (112th):

Thank you, Mr. Speaker. Mr. Speaker, the Clerk has an Amendment. It is LCO --

SPEAKER DONOVAN:

Excuse me, Representative. We're on an Amendment right now, so you'll just have to wait until after we do that first.

REP. HOVEY (112th):

I always have bad timing, Mr. Speaker, thank you.

SPEAKER DONOVAN:

Thank you, Representative. Representative D'Amelio on the amendment.

REP. D'AMELIO (71st):

Thank you, Mr. Speaker. Mr. Speaker, I rise in strong support of this Amendment. This issue's been before the Insurance and Real Estate Committee for a

few years here in the House, and I think Connecticut is being used as a model throughout the country on the legislation that we've passed over the years dealing with this very issue.

So we need to be congratulated here in Connecticut.

Thank you, Mr. Speaker.

SPEAKER DONOVAN:

Thank you, Representative. Will you remark further on the Amendment? Remark further on the Amendment?

If not, let me try your minds. All those in favor of the Amendment please signify by saying Aye.

REPRESENTATIVES:

Aye.

SPEAKER DONOVAN:

All those opposed, Nay. The Ayes have it. The Amendment is adopted.

Will you remark further on the Bill as amended? Representative Hovey.

REP. HOVEY (112th):

Thank you, Mr. Speaker. Mr. Speaker, the Clerk has an Amendment, LCO 8640. Would you please ask the Clerk to call it and I be allowed to summarize.

SPEAKER DONOVAN:

Would the Clerk please call LCO 8640, which will be designated House Amendment Schedule "B".

THE CLERK:

LCO Number 8640, House "B", offered by Representative Hovey.

SPEAKER DONOVAN:

The Representative seeks leave of the Chamber to summarize. Any objection? Hearing none, Representative, you may proceed with summarization.

REP. HOVEY (112th):

Thank you, Mr. Speaker. Mr. Speaker, a lot of the people in this Hall will know that I've been referring to this as my baby Amendment.

Basically what this does is, when you have a bay, you have 31 days to inform your insurer that you've had that child. And of course, if it's a perfect delivery and everything goes exactly the way you would like it to, probably 31 days does work.

But if it doesn't work, this moves it to 61 days. I move adoption.

SPEAKER DONOVAN:

The question is on adoption. Will you remark further? Will you remark further on the Amendment? Representative Megna.

REP. MEGNA (97th):

Thank you, Mr. Speaker. Mr. Speaker, I rise in support of the Amendment. We've had this issue before us in front of the Insurance and Real Estate Committee and I support it and it's a friendly Amendment.

Thank you, Mr. Speaker.

SPEAKER DONOVAN:

Thank you, Representative. Care to remark further on the Amendment? Representative Alberts.

REP. ALBERTS (50th):

Thank you, Mr. Speaker. I, too, agree with the Chairman of the Insurance Committee. This is a good Amendment and ought to pass.

SPEAKER DONOVAN:

Thank you, Representative. Do you care to remark further on the Amendment?

If not, let me try your minds. All those in favor of the Amendment please signify by saying Aye.

REPRESENTATIVES:

Aye.

SPEAKER DONOVAN:

Opposed, Nay. The Ayes have it. The Amendment is adopted. Will you remark further on the Bill as amended? Will you remark further on the Bill as amended?

If not, staff and guests please come to the Well of the House. Members take your seats. The machine will be opened.

THE CLERK:

The House of Representatives is voting by Roll Call. Members to the Chamber.

The House is voting by Roll Call. Members to the Chamber, please.

SPEAKER DONOVAN:

Have all the Members voted? Have all the Members voted? Please check the Roll Call board to make sure your vote's been properly cast.

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

THE CLERK:

Senate Bill Number 18, as amended by House "A" and "B".

Total Number Voting 138

Necessary for Passage 70

Those voting Yea 137

Those voting Nay 1

Those absent and not voting 13

SPEAKER DONOVAN:

The Bill as amended is passed.

Will the Clerk please call Calendar 590.

THE CLERK:

On Page 28, Calendar 590, Substitute for Senate Bill Number 764 AN ACT CONCERNING THE MATTABASSETT DISTRICT. Favorable Report of the Committee on Finance, Revenue and Bonding.

SPEAKER DONOVAN:

Representative Linda Gentile, you have the floor, madam.

REP. GENTILE (104th):

Good afternoon, Mr. Speaker. Mr. Speaker, I move for acceptance of the Joint Committee's Favorable Report and passage of the Bill.

SPEAKER DONOVAN:

The question is on acceptance of the Joint Committee's Favorable Report and passage of the Bill. Will you remark?

REP. GENTILE (104th):

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DEBRA POLUN: Thank you so much.

SENATOR CRISCO: Representative Morin. Is Representative Morin here?

Vickie Veltri on Senate Bill 17.

SB18 SB21

VICTORIA VELTRI: Good afternoon, Senator Crisco, Senator Kelly, Representative Sampson.

For the record, I'm Vickie Veltri, and I'm the acting healthcare advocate for the State of Connecticut, and I'm here to testify on Senate Bill 17.

OHA -- OHA endorses Senate Bill 17. It's fair to say that the consumer protections that we've enacted in our statutes are a reflection of the state's public policy to ensure coverage for medically necessary care.

That said, as you know, OHA has long supported independent cost-benefit analysis of the consumer protections included in our health insurance statutes.

As part of a larger discussion on healthcare reform, this type of analysis is obviously helpful.

We support the reviews as an objective method to assist policymaker, so concerns about costs are valid.

But OHA notes that the review of the consumer protections contained in Senate Bill 17 concluded that adding those protections put the estimated cost of covering these services at about 71 cents per member per month, plus about zero to three percent of premium cost

for wellness programs.

The announcements deem that these costs will not impact the existing healthcare financial burden of enrollees.

We think that this analysis shows that the benefits of covering such important benefits far outweighs the costs, in addition, offering programs to improve wellness consistent with everyone's goals of lowering healthcare costs down the line.

So in conclusion, SB17, we support it.

SENATOR CRISCO: Thank you, Vickie.

Any questions of the healthcare advocate? Thank you very much. Vickie, I should have kept you up there. Senator Looney isn't here, is he?

Vickie, do you want to testify on 19 -- 18? Vickie? You want to come up and testify on 18?

VICTORIA VELTRI: Sure.

Actually, on Senate Bill 18 what we really wanted to remark was that we supported the provision that required the utilization review company to furnish the provider and enrollee with the information the company uses to make its determination.

This kind of necessary -- information is necessary for preparation of an appeal. It's also consistent with what -- the provisions of the Affordable Healthcare Act and the regulations about appeals, so we support that provision.

half a million dollars a year, depending on the patient.

Certainly that was the cost at the end of my mom's life, that it was probably averaging, that cost, with hospitalization and different types of treatment that an individual has to go through.

Thanks, Mr. Chairman.

SENATOR CRISCO: Thank you, Representative.

Any other questions for the doctor? Thank you very much.

MARC GLICKSTEIN: Thank you very much.

SENATOR CRISCO: I appreciate all your -- your work.

We will now revert back to the state official part of our testimony.

Senator Prague.

SENATOR PRAGUE: Senator Crisco and members of the Insurance Committee -- first of all, Senator Crisco, thank you for going back and allowing me to testify.

SB18

For the record, I'm Senator Edith Prague of the 19th District. I frequently admire the kinds of bills that this committee deals with. Today I'm here to testify in support of Senate Bill 32, Senate Bill 34, Senate Bill 15, and I certainly support Senate Bill 10d.

Really this is very good work on the part of this committee, but I want to address Senate Bill 32 and Senate Bill 34 at the moment.

the seniors under Senate Bill 15. The Insurance Department under our previous insurance commissioners granted Metropolitan Life a 39 percent increase in the premium for their long-term care insurance policy.

Now, many of these seniors had the policy with Travelers, and when Metropolitan Life bought out Travelers, they bought their -- the business. Along the way, Metropolitan decides they're going to ask for 39 percent, a 39 percent increase.

I'll back up a minute. Some of them got a 30 percent increase. Some of them got a 39. The insurance commissioners granted them this increase without any input, without any hearing. The seniors never had a chance to come in and testify, and I can tell you that many of them have called me and said, you know, I don't know what I'm going to do. When the next premium -- annual premium is due, that premium is going up. And some of them are going to have to drop their policies.

There must be a public hearing when any policy over a ten percent increase -- when this kind of request comes in to the Department, there must be a public hearing. This is totally unconscionable, and our previous commissioners didn't do the State of Connecticut any favors. Did Metropolitan a big favor but didn't do the citizens of this state any favor, let me tell you.

The other policy that -- the other bill that you have here -- well, I won't take any more of your time. I appreciate the time you've given me. I --

SENATOR CRISCO: Senate Bill 18, the appeals of

health insurance benefit denial.

SENATOR PRAGUE: Oh, yes, yes, I am particularly interested in supporting that bill. So thank you very much, committee members. We've got some work to do.

Is there any questions? I'd be happy and try and answer them for you.

SENATOR CRISCO: Thank you, Senator.

Are there any questions of Senator Prague? Any questions?

Yes, Representative Johnson.

REP. JOHNSON: Thank you, Mr. Chairman. And thank you for your testimony, Senator Prague.

I just wondered if you had any experience at all with needing any appeals for health insurance benefit denials. Have you had any situations where you've been involved with any appeals?

SENATOR PRAGUE: Sometimes the appeals that go before the Utilization Review Committee, you know, are not successful. Then they have to go to the Department for an external appeal.

This is pretty disastrous for people who already need this medical attention. If it's documented by a physician, I don't believe that the insurance industry has the right to deny those services or those benefits that a doctor has ordered for a patient.

Those appeals are excruciating.

REP. JOHNSON: You're speaking of Utilization of

Review Committee type appeals where they're reviewing a health maintenance organization type determination.

SENATOR PRAGUE: Or they're reviewing services and benefits that have been denied to a patient.

REP. JOHNSON: Thank you so much. Thank you, Mr. Chairman.

SENATOR CRISCO: Any other questions? Yes, Representative Coutu.

SB 32
SB 34

REP. COUTU: Thank you, Mr. Chairman. And thank you, Senator, for your testimony today.

Relating to trying to decipher this quickly, because I don't know as much as you know about this issue, one of them is if an employer -- employee is getting compensation and then they receive this additional funding and then -- what you're stating is that the insurance company takes some of their income; is that correct?

SENATOR PRAGUE: No. What I'm saying, Representative Coutu, is that you as an employee pay for this coverage in case you become disabled. You pay for coverage through your employer, it's usually a group policy, through your employer, for a percentage of your salary because you want your family to be protected.

But you then have -- you know, were so disabled with this disabling event that you apply for Social Security Disability because you know you won't be able to go back to work.

So Social Security grants you Social Security Disability. That Social Security is then

medically necessary by a physician should be covered by insurers, and that's what I'll leave at that.

But to focus on the more important part of the bill is the expansion of wellness programs, which we fully support. All we ask is that we add language to the bill that also allows insurers to acknowledge programs that are developed by physicians, employers and other entities to meet the criteria as wellness programs and also be eligible for some type of award or compensation within the insurance plan.

SENATOR CRISCO: Thank you, Ken. Any questions? Thank you very much.

Proceeding to Senate Bill 18, Susan? Susan's not here. Not here?

SUSAN HALPIN: I switched sides of the room.

SENATOR CRISCO: Gone from the right to the left?

SUSAN HALPIN: Right in the middle. Good afternoon, my name is Susan Halpin. I'm here on behalf of the Connecticut Association of Health Plans.

I'm here before you today to testify in opposition to Senate Bill 18, An Act Concerning Appeals of Health Insurance Benefits Denials.

I think it's really important to recognize that Connecticut has already taken significant action in the area of medical necessity determinations and is in fact held up as a model around the country.

The 1999, the Managed Care Act instituted an independent third-party external appeal mechanism for both consumers and providers.

Matters and questions go to the Department of Insurance, who then refer them to an outside entity that's made up of -- by physicians within the specialty practice that's in question.

They review all relevant information from both sides and issue a decision that is binding on both parties.

DOI has reported previously that appeals of this nature generally split around 50-50, with half being decided in favor of the provider and the other half in favor of the member, suggesting that the process works and fairly arbitrates matters of legitimate dispute.

We believe very much that further legislation in this area of healthcare is unnecessary and unwarranted. The external appeal process is a well-recognized effective manner to resolve questions around medical necessity. The new processes that are established under Senate Bill 18 are enormously cumbersome and they're virtually unworkable in the current system.

If enacted, it would be, unquestionably, one of the single-most expensive mandates ever passed.

Again, please keep in mind that all new provisions must be viewed in the context of the federal reform efforts and the essential health benefits that will be designed therein.

We ask you to oppose the bill. We believe the consumer protections that are currently in

place address the issue at hand. Thank you for your attention and happy to answer any questions.

SENATOR CRISCO: Thank you, Susan. No questions? Thank you very much.

SUSAN HALPIN: Thank you.

SENATOR CRISCO: Dina, is Dina here? Christine?

CHRISTINE CAPPIELLO: Good afternoon, Senator Crisco, Representative Megna and members of the Committee. My name -- for the record, my name is Christine Cappiello. I'm the director of government relations for Anthem Blue Cross Blue Shield in Connecticut, and I'm hear to testify against Senate Bill 18, An Act Concerning Appeals of Health Insurance Benefits Denials.

I'd like to take a moment to speak on a different section of the bill. We're really unsure of the reason for this legislation before you today. Susan Halpin alluded to the utilization review statute. They were passed in 1997 and they were held up as models across the country, and they've been modified over the years to produce 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 has over the years -- that this law has been in place.

Almost every section of this bill purports to take the current UR process and turn it on its head and sets a standard where insurers would be left to approve and pay for any service that's requested because the administrative

burden and inability to manage utilization will leave the carriers no other choice.

One of the best examples is the proposed change to the definition of medical necessity to say the burden of proof to prove services requested is not medically necessary.

While on the face of it it seems 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 requesting physicians to prove the information to make that decision, but there is nothing to compel them, and we would be left to approve a request because we couldn't meet that burden of proof standard for denying coverage.

I have reached out to our medical directors for some real-life requests in coverage under the new burden of proof standard. We would be compelled to cover: Obesity surgery for people with a body mass index of 25, which is the normal weight; a power chair for a person with a sprained ankle; coverage for bicycle to travel to work; coverage for hot tubs; a seven-day inpatient stay requested so a family could go camping; frequent requests for cosmetic surgery said to be medically necessary.

So just in conclusion, we would want to leave the Committee with this very important thought: The legislature worked very hard to align the UR process with the federal Department of Labor relations and have sensible criteria to govern the UR and appeals process for Connecticut citizens, and this legislation would simply unravel that hard work and do nothing but add costs to

healthcare.

We strongly urge the Committee to reject this legislation.

SENATOR CRISCO: Thank you, Christine. Thank you very much.

Dina?

DINA BERLYN: Good afternoon, Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee. My name is Dina Berlyn. You may know me as Senator Looney's counsel and executive aide, but I'm here now as a patient with multiple sclerosis to testify on Senate Bill 21, An Act Concerning Health Insurance Coverage for Routine Patient Care Costs for Clinical Trial Patients, and Senate Bill 18, An Act Concerning Appeals of Health Insurance Benefits Denials.

I have researched and written on the issue of routine patient care in clinical trials, and what I have found out about the issue is that the cancer-only provision in our statutes doesn't make a whole lot of sense.

In 2001, the General Assembly passed 01-171, which required coverage of routine patient care for cancer. And they're great goals, but the bill in its final form required coverage only for cancer trials, and a number of insurers also covered these expenses for cancer.

And for rare -- trials for rare diseases, if insurers deny coverage of these costs, which is not asking insurers to cover anything that they shouldn't be asked to cover, it's just

the routine care that they would have to cover patients if they weren't in a clinical trial. It's covering the standard of care. So if they -- if costs are denied for rare diseases, then -- for trials of rare diseases, then there's no way that any of the trials are going to happen.

There's also evidence that routine patient care costs for clinical trial patients are essentially equivalent as routine patient care costs for patients not in clinical trials.

And I believe that in many -- for many patients with diseases such as multiple sclerosis, the routine care costs are actually less, because -- like the drug I take is $3,500 a month, and there's no way that I would have an increased routine care cost of $3,500. And of course the insurer would not have to pay for the experimental drug.

So, you know, it -- is that my beep? So anyway, some of this is dealt with in the Affordable Care Act but only for cancer or life-threatening disease, very narrow definition of life-threatening to leave out all the chronic disease.

Section 15 is also great, which was expanding the ability to use off-label drugs. And in terms of Senate Bill 18, the -- there's a lot of problems in the process of denials, which is one is that you don't get the -- the complete record of your case, in which case then the insurance company is the one that has all the information which generally the burden of proof lies with the party who has all the information.

And since they don't and will refuse to give

you the complete record in your case, then they need to have the burden of proof to show that it's not a medical necessity.

And I guess I'm beyond my time, but I thank you very much for bringing both these bills to the public hearing.

SENATOR CRISCO: Thank you very much. Questions? Thank you.

DINA BERLYN: Thank you.

BRIAN QUIGLEY: Dr. Bhaya. Excuse me if it's been mispronounced.

MAHESH BHAYA: Good afternoon, Senator Crisco, Representative Megna, other distinguished members of the Committee.

For the record, my name is Dr. Mahesh Bhaya and I am a barred-certified ENT -- ear, nose and throat -- surgeon in Waterbury. And I'm here on behalf of 1500 physicians in a variety of medical specialties in support of this bill, Senate Bill 18.

I would like to thank this Committee for once again bringing an important transparency bill to public hearing and offering people like us, those on the forefront -- forefront of healthcare delivery an opportunity to shed some light on some of the problems that we face when dealing with the managed care industry's denial of medical claims. We support any such bill which will improve the quality of healthcare.

Now, this bill will do several things to improve the delivery of care by first specifying a presumption of medical necessity

for appeals of health insurance benefits denials.

It will also require documents and information that were considered by the managed care organization administrator in a final determination when they refuse to certify an admission, a service, a procedure or extension of stay to be provided to a provider of record and to an enrollee.

To some, this may seem ridiculous that this information is not required by a managed service organization when a claim is denied, but the fact is that this information is seldom given.

In fact, most MCOs reject claims with one-line denials that simply say not medically necessary or experimental treatment, despite a treatment being the customary by practicing medical doctors.

This vague denial explanation results in hours of administrative burden for the provider and long delays in reimbursement.

The second thing this bill does is requires dispensation and coverage of a prescribed drug during an appeal of a determination not to certify such dispensation.

Frequently, patients -- and as you heard from Dina -- suffer tremendous setbacks due to an appeal of determination of a medication or treatment plan that is later overturned. This is not only frustrating to the physician but also adds to the overall cost of healthcare.

By supporting this bill, healthcare providers will be better equipped to combat denials of

treatment and more effectively take care of the needs of our patients. This bill will also support the effort of this Committee to bring transparency into every aspect of the healthcare delivery system.

And in conclusion, you know, the government is actually doing a fairly good job of what we're talking about. I have something I could gladly share with the Committee from Medicare, which is basically a denial -- which is explained beautifully as to request this request was denied.

So I'm not saying that medically -- that everything should be approved by the bearers. I mean, yes, it has to be medically necessary.

And we base decisions on, you know, we have a lot of evidence based recommendations. We base our decisions on that.

And if we don't satisfy that, it's fair enough to get such nice long denials, but I would hope that we can get the private payers to do the same.

Thank you once again for your consideration.

SENATOR CRISCO: Thank you, Doctor. And if you give that to our clerk, we'll make sure every Committee member receives it.

Are there any questions? Thank you very much for your time.

MAHESH BHAYA: Thank you so much for your time.

SENATOR CRISCO: You're welcome.

Proceeding to Senate Bill 21 -- Dina, did you

JOINT
STANDING
COMMITTEE
HEARINGS

INSURANCE AND
REAL ESTATE
PART 3
667 – 987

2011

Office of the
Healthcare
Advocate
STATE OF CONNECTICUT

Testimony of Victoria Veltri
Acting Healthcare Advocate & General Counsel

Before the Insurance and Real Estate Committee
In support of SB 12, SB 15, SB 17, SB 18 and SB 21
January 27, 2011

Good afternoon, Representative Megna, Senator Crisco, Senator Kelly, Representative Coutu, and members of the Insurance and Real Estate Committee. For the record, I am Vicki Veltri, Acting Healthcare Advocate and 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 SB 12, AN ACT CONCERNING COPAYMENTS FOR PREVENTIVE SERVICES. OHA has supported this measure in the past. While the Patient Protection and Affordable Care Act (ACA) prevents non-grandfathered plans from applying copayments to preventive services, grandfathered plans are not subject to this provision of the ACA. Passage of SB 12 will ensure that Connecticut residents covered in any type of plan have access to preventive services, encouraging better health care. SB 12's list of preventive services appears to be more comprehensive than the list under the ACA. The committee may wish to consider aligning the definition of preventive services in SB 12 to that in the ACA.

OHA supports the concept of SB 15, AN ACT CONCERNING RATE APPROVALS FOR LONG-TERM CARE INSURANCE POLICIES. It is past time to ensure the availability of public comment and transparency in the long-term care insurance market. Individuals who are subject to repeated double digit rate increases in the long-term care market deserve the chance to scrutinize and comment on proposed rate increases.

OHA supports SB 18, AN ACT CONCERNING APPEALS OF HEALTH INSURANCE BENEFITS DENIALS. This bill contains provisions consistent with our recent proposals that provide deference to a provider's medical judgment. No reviewer in a utilization review company can ever truly step completely into the shoes of a provider in the application of medical judgment in a specific case. Every year, the utilization review companies, many of whom are subsidiaries of the insurers themselves, are making medical determinations. In our experience, the insurers are going beyond medical necessity coverage determinations to substitute their medical judgment for that of the providers. This happens in surgical cases and behavioral health cases more and more frequently. An insurer may determine that a service is not medically necessary, but it is not the insurer's role to practice medicine on a patient they have never examined – suggesting an alternative, lower-level of care or a different kind of surgery, for example. While the insurers might argue that the decisions they are making are merely coverage determinations, more often than not, they are de facto denials of services or treatment. In most cases, consumers cannot afford to go ahead with a medical treatment that has been denied.

The insurers will undoubtedly testify that to provide a presumption of medical necessity for a provider's judgment will destroy managed care. We reject that notion. Insurers can still subject a service to prior authorization or post-service utilization review. The only change this bill makes is to shift the burden to where it properly belongs, onto the insurers. It is not unheard of for provider's decisions to be accorded deference. Such deference exists in Medicaid and in Social Security for disability determinations. We've witnessed a significant level of second guessing of providers; MCO peer reviews that are not based on a complete record; and, arbitrary limitations made on approved services. We need to restore deference to the providers who actually examine and treat the patient.

OHA supports the provisions of SB 18 requiring the utilization review company to furnish a provider and an enrollee with the information the company used to makes its determination. This information is crucial for the preparation of an appeal.

OHA also supports SB 21, AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR ROUTINE PATIENT CARE COSTS FOR CLINICAL TRIAL PATIENTS. The limitation of coverage for routine patient care costs to clinical trials for cancer is no allowable under Connecticut law. However, there are treatments for other disabling, progressive or life-threatening medical conditions that also undergo clinical trials. With rapidly advancing medical technology, it's likely that clinical trials for the treatment of illnesses other than cancer will be available to those who cannot succeed on approved treatments. The bill logically links eligibility for reimbursement to Medicare clinical policy in addition to the existing options. The bill appropriately limits coverage of routine patient care costs to individuals with disabling, progressive, or life-threatening medical conditions. This is a fair and overdue extension of our current statutory scheme.

Finally OHA supports the common sense proposals of SB 17, AN ACT CONCERNING WELLNESS PROGRAMS AND EXPANSION OF HEALTH INSURANCE COVERAGE. OHA has testified in favor of this bill in the past. UConn analysts put the estimated cost of covering these services at about $.71 per member per month plus 0-3% of premium costs for wellness programs. The analysis deemed these costs would not impact the existing health care financial burden of enrollees.

Thank you for the opportunity to submit this testimony. If you have any questions, please contact me at victoria.veltri@ct.gov of 860-297-3982.

Quality is Our Bottom Line

p 15
Ln 14
Susan H.

Insurance Committee Public Hearing
February 3, 2011
Connecticut Association of Health Plans

Testimony in Opposition to

SB 18 AAC Appeals of Health Insurance Benefits Denials.

The Connecticut Association of Health Plans respectfully urges the Committee's rejection of SB 18 AAC Appeals of Health Insurance Benefits Denials.

Connecticut has already taken significant action in the area of medical necessity determinations and is, in fact, held up as a model around the country. The 1999 Managed Care Act instituted an independent, third party, external appeal mechanism for both consumers and providers. Matters in question are forwarded via the Department of Insurance to an outside entity made up of physicians within the specialty practice in question. They review all relevant information from both sides and issue a decision that is binding on both parties.

The Department of Insurance has reported previously that appeals of this nature generally split about 50/50 with half being decided in favor of the provider/member and half in favor of the health plan suggesting that the process fairly arbitrates matters of legitimate dispute.

Further legislation in this area of health care is unnecessary and unwarranted. The external appeal process is a well-recognized effective manner in which to resolve questions around medical necessity. The new process established under SB 18 is enormously cumbersome and virtually unworkable. If enacted, it would be, unquestionably, one of the single most expensive mandates ever passed.

When viewed in the context of the Patient Protection and Affordable Care Act of 2010 (PPACA), SB 18 becomes even more costly and burdensome. Please keep in mind that any coverage above and beyond the yet to be determined "essential health benefits," gets no federal funding and is required to be borne by the state. Passage of this legislation could be a costly mistake.

Given the consumer protections in place under the State's current external appeal law, we would respectfully submit that the intent of SB 18 - to assure that medical professionals are making final decisions with respect to covered services - is already covered.

We urge your rejection. Many thanks for your consideration.

280 Trumbull Street | 25th Floor | Hartford, CT 06103-3597 | 860.275 8372 | Fax 860.541.4923 www.ctahp.com

p 1s
Ln 20

Testimony of the
Connecticut ENT Society
Connecticut Urology Society
Connecticut Society of Eye Physicians
Connecticut Dermatology and Dermatologic Surgery Society
Connecticut Chapter of the American College of Surgeons
Connecticut Orthopaedic Society
In SUPPORT of
SB 18 AN ACT CONCERNING APPEALS OF HEALTH INSURANCE BENEFITS DENIALS.

To the Insurance and Real Estate Committee
On
Thursday Feb 3, 2011

Good Morning, Senator Crisco, Representative Megna, and other distinguished members of the Insurance and Real Estate Committee. For the record my name is Dr. Mahesh Bhaya, and I am a board certified otolaryngologist, practicing in Waterbury, CT. I am here today to represent more than 1500 physicians in a variety of medical specialties **in support** of SB18 An Act Concerning Appeals of Health Insurance Benefits Denials. I would like to thank this committee for once again bringing an important transparency bill to public hearing and offering those on the front line of healthcare delivery an opportunity to shed some light on some of the problems physicians face when dealing with the managed care industries denial of medical claims.

We support any bill which will improve the quality of health care in this state by providing insight and transparency into the medical claim process. This bill would do several things to improve the delivery of care by first specifying a presumption of medical necessity for appeals of health insurance benefits denials, requiring documents and information that were considered by the MCO administrator in a final determination not to certify an admission, service, procedure or extension of stay to be provided to a provider of record and to an enrollee. To some this may seem ridiculous that this information is not required by a managed service organization when a claim is denied but the fact of the matter is that this information is seldom given, in fact most MCOs reject claims with one line denials that simply say" not medically necessary or experimental treatment, despite a treatment or procedure being the customary treatment plan by practicing medical doctors. This vague denial explanation results in hours of administrative burden for the provider and long delays in reimbursement.

The second thing this bill does is it requires dispensation and coverage of a prescribed drug during an appeal of a determination not to certify such dispensation. Frequently patients suffer tremendous setbacks due to an appeal of determination of a medication or treatment plan that is later overturned. This is not only frustrating to the physician but also adds to the overall cost of healthcare in the long run. By supporting SB 18 Healthcare providers will be better equipped to combat denials of treatment and more effectively take care of the needs of our patients. This bill will also support the effort of this committee to bring transparency into every aspect of the healthcare delivery system.

Thank you for your consideration and I would be happy to entertain any questions.

Anthem.

P. 15
Ln 16

January 27, 2011

Christine C.

Statement
Of
Anthem Blue Cross and Blue Shield
On
SB 18 An Act Concerning Appeals of Health Insurance Benefit Denials

Good afternoon Senator Crisco, Representative Megna 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 18 An Act Concerning Appeals of Health Insurance Benefit Denials.

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 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.

Anthem.

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

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Testimony of the Connecticut Insurance Department

Before
The Insurance and Real Estate Committee

February 3, 2011

Senate Bill No. 18--An Act Concerning Appeals of Health Insurance Benefit Denials

The Connecticut Insurance Department offers the following comments on Senate Bill 18 – An Act Concerning Appeals of Health Insurance Benefit Denials.

Section 2719 of the Public Health Service Act as amended by the Patient Protection and Affordable Care Act of 2010 (P.L.111-148) (PPACA), as amended, provides a system for applicability of either a State external review process or a Federal external review process. For States such as Connecticut which have existing State external review processes, the U.S. Health and Human Services Department interim regulations require that by July 1, 2011, the State must be fully compliant with the National Association of Insurance Commissioners' (NAIC) Model External Review Act or the State oversight over external appeals will be ceded to the Federal external appeal process to be managed by the Departments of Health and Human Services and Labor. For plans and issuers not subject to an existing State external review process (including self-insured plans), a Federal process will apply for plan years (in the individual market, policy years) beginning on or after September 23, 2010.

HHS has indicated that our law does not conform to the newly revised NAIC model. Our State external appeal law needs to be amended, in order to avoid a July 1, 2011, "take over" by HHS of our external appeal program. As part of this process, we also need to revise our utilization review law. The proposed change in SB18 is not consistent with the NAIC Model and could be viewed as making our process non-compliant. Therefore, we recommend that the Committee does not adopt this provision. The Connecticut Insurance Department will be proposing a separate bill to revise our State's external appeal and utilization review statutes to fully adopt the NAIC models to retain state control pursuant to PPACA directives.

Thank you for allowing the Department the opportunity to offer comments to this bill. As always, we are available to answer any questions the Committee has.

FTR

SENATOR MARTIN M. LOONEY
Majority Leader

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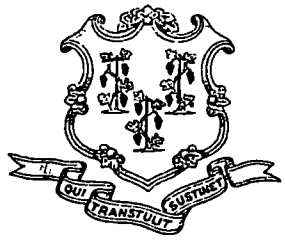
www.senatedems.ct.gov



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State of Connecticut

SENATE
11th District

January 27, 2011

Good afternoon Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee. I am here to testify in support of two bills that are on the agenda today: S.B. No. 21 AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR ROUTINE PATIENT CARE COSTS FOR CLINICAL TRIAL PATIENTS and S.B. No. 18 AN ACT CONCERNING APPEALS OF HEALTH INSURANCE BENEFITS DENIALS

S.B. No. 21 AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR ROUTINE PATIENT CARE COSTS FOR CLINICAL TRIAL PATIENTS would expand coverage of routine patient care costs for clinical trial patients to clinical trials for serious or life threatening diseases and ensure that third party payers retain their responsibility to patients. In 2001 the Connecticut General Assembly passed PA 01-171 which required insurers to sustain their responsibility to patients who participate in clinical trials for cancer. At that time I expressed my

S.B. No. 18 AN ACT CONCERNING APPEALS OF HEALTH INSURANCE BENEFITS DENIALS, would create greater equity for patients who are denied services from managed care organizations, health insurers, or utilization review companies ("insurers"). Currently, when one of these organizations denies coverage, the burden of proof in the appeals process is on the provider and the patient to prove that the service or drug, or device is medically necessary. One of the problems with this system is that only the insurer knows why the claim was denied. In general, the burden of proof in any case should be placed on the party who has the information. In this case that party is the insurer. SB 18 would create an assumption that medical treatments, drugs, and devices that are ordered by a licensed provider are medically necessary. It places the burden of proof in its rightful place, on the insurer that is denying coverage.

In addition, the insurers are not always forthcoming with the record in the case; access to the record would offer the patient and the provider critical information as to how the decision to deny coverage was formulated. This bill would require that the insurer provide this information to the patient and provider; the patient and physician should not be left guessing as to the reasons for denial. This legislation would allow them a chance to present the counter-argument with access to all the appropriate information; it is simply a matter of fairness.
In cases where the denial of service is in regard to a prescription drug, the bill would require that the insurer provide the patient with the drug for the course of

the appeal. This protects the patient by giving him or her access to needed medication and encourages the insurer to resolve the case quickly.

Again, thank you for raising these important bills which would assist patients in our healthcare system.

P 15
Ln 18

Dina Berlyn
30 Morris Street
Hamden, CT 06517 (203) 776-3869

January 27, 2011

Good morning, Sen. Crisco, Rep. Megna and members of the Insurance and Real Estate Committee. My name is Dina Berlyn. Some of you might recognize me at the LOB as State Senate Majority Leader Martin Looney's Counsel and Executive Aide, which I am, but I am not here in that role. I am a patient with multiple sclerosis. I am here to testify on two healthcare policy issues of deep personal interest to me: coverage of routine patient care costs in clinical trials and the burden of proof in appeals from benefit denials. Both S.B. No. 21 AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR ROUTINE PATIENT CARE COSTS FOR CLINICAL TRIAL PATIENTS and S.B. No. 18 AN ACT CONCERNING APPEALS OF HEALTH INSURANCE BENEFITS DENIALS would make our healthcare coverage more rational and compassionate for patients.

I have researched, written, and been published on coverage of routine patient care in clinical trials, and I want to share with you my discoveries about this matter -- particularly the irrational nature of the for-cancer-only provision in our statutes.

In 2001, the Connecticut General Assembly passed PA 01-171 AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR CANCER CLINICAL TRIALS, HEARING AIDS FOR CHILDREN AGE TWELVE AND YOUNGER, PAP SMEAR TESTS, COLORECTAL CANCER SCREENING AND MAMMOGRAMS, PSYCHOTROPIC DRUG AVAILABILITY AND MEDICAID COVERAGE FOR

to medical progress. President Clinton changed Medicare Policy so that Medicare covers routine care costs for clinical trials. In the Affordable Care Act Congress requires coverage of routine patient care costs ***but*** only in trials for cancer or other life-threatening diseases. The definition for 'life-threatening' is extraordinarily narrow and thus will not include the majority of chronic and disabling diseases. I do hope that Congress will act to make the language in the Affordable Care Act consistent the rational and enlightened policy developed by the Centers for Medicare & Medicaid Services. However, since the prospects for Congressional action are unclear, Connecticut should pass this legislation. I strongly urge you to require that insurers sustain their responsibility to patients who enter clinical trials.

In addition, I applaud the inclusion of section 15 which would expand the off-label use of drugs beyond the use of such drugs for cancer. There are many drugs which, although they have been shown to be effective for diseases other than the one for which they were originally approved to treat, are technically not approved for these other diseases. This is the situation I encountered that led to my experience with the system for appeal of a healthcare denial. Doctors, not insurers should engage in the practice of medicine.

Most unfortunately, I have experienced first hand the appeals process for healthcare coverage denials. This experience is why I believe that S.B. No. 18, AN ACT CONCERNING APPEALS OF HEALTH INSURANCE BENEFITS DENIALS, is needed. At the beginning of the process in my case it was unclear that the denial was

coming from the pharmacy benefits manager; Caremark would not give straight answers. Once it became clear that my doctor had renewed the prescription appropriately and the problem was a denial by Caremark, I began the appeal process. I lost at the first two rounds of internal appeal; there is not much of an opportunity to present your case in these rounds especially since the insurer does not disclose their records in your case to you. I made repeated requests to Caremark for their records in my case but NEVER received them. I did receive a fax which started at page 50 and purported to be the record but in fact it was a copy of the appeal form from the department of Insurance (which I already had). Once the internal rounds were done, I filed an external appeal with the state Department of Insurance. I spent over 20 hours researching and writing this document. I included journal articles supporting the use of Provigil for fatigue in MS (it is the most common symptom in the disease). I pointed out that this drug has been extraordinarily effective in my case and I noted that Caremark made a number of claims that were not backed up by evidence.

Once the Department of Insurance receives an appeal, it sends the appeal out to their external reviewer and to the insurer. When Caremark received my letter they chose to cover the prescription rather than go through the appeal. I believe that they feared that if they lost this appeal that they would not be able to deny others with a prescription for the same drug. When a healthcare provider prescribes a drug for a specific condition which has been effective for a patient and for which there is evidence of effectiveness, an insurer should not be allowed to substitute its judgment for that of the skilled providers. In addition, a patient should not be forced to forego a needed prescription during the

course of the appeal; this can create an undue hardship on these patients. This bill contains reforms which would assist patients in receiving the care they require.

I am most appreciative of your efforts on these issues of extraordinary importance to Connecticut's citizens.

S – 626

CONNECTICUT
GENERAL ASSEMBLY
SENATE

PROCEEDINGS
2011

VOL. 54
PART 15
4617 – 4950

call vote? The machines will be open.

THE CLERK:

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

THE CHAIR:

Have all members voted? Have all members voted? The machine will be locked. And Mr. Clerk will you call the tally, please?

THE CLERK:

Madam President --

Total number of voting	35
Those voting Yea	32
Those voting Nay	3
Absent and not voting	1

THE CHAIR:

The bill is passed.

Mr. Clerk.

THE CLERK:

Madam President, calling from Calendar page 3, Calendar Number 115, Senate Bill Number 18, AN ACT CONCERNING APPEALS OF HEALTH INSURANCE BENEFITS

DENIALS, Favorable Report of the Insurance Committee.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

I'm sorry, Madam President, I can't hear you.

THE CHAIR:

Senator -- can -- can we -- can we please lower our voices. Senator Crisco is about to bring out a bill.

SENATOR CRISCO:

Thank you, Madam President.

THE CHAIR:

Thank you.

SENATOR CRISCO:

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

THE CHAIR:

Acting on approval of the bill, will you remark, sir?

SENATOR CRISCO:

Thank you, Madam President.

Madam President, this bill establishes a presumption of medical necessity for appeals sent to

review entities on behalf of the Insurance Commissioner. This will cause the Utilization Review Process to defer to the patient care providers medical judgment rather than the utilization reviewers, which is so important. It also requires them to vet a final determination rejecting claim, managed care companies, health insurers and utilization review companies must provide to patients and their care providers documents and information considered in such a final determination.

In addition, the bill requires that any appeal process concerning prescription medication coverage of the prescribed drug must continue. We also limit the number of documents required in the bill, Madam President.

THE CHAIR:

Thank you.

SENATOR CRISCO:

And Madam President, I will like to yield to Senator Looney.

THE CHAIR:

Senator Looney, will you accept the yield, sir?

SENATOR LOONEY:

Yes, thank you.

Thank you, Madam President, and thank you to Senator Crisco for the yield and for his work and that of the Insurance Committee and -- in bringing out this proposal.

Madam President, this bill is aimed at making sure that those who would seek to appeal a denial of coverage for a -- either a procedure or medication will be able to do so with the full information upon the request, that was used in -- in making that initial denial. Because often we know up to this time that individuals are often at a disadvantage because they are not fully aware of the basis upon which a denial of an admission service, procedure, extension or stay and so on as defined in the bill will -- upon which that was based.

So this would allow the individual to receive and both the provider and the enrollee to have the information upon which that decision was made so that a more fully informed appeal can be brought if in fact it is decided by the individual and by his or her provider that an appeal should be made. So it is a -- it just is a -- a provision for clarity of information so that there will be a more of an informed basis for -- first of all, a decision whether or not to appeal

and secondly, to have the basis for an informed appeal.

Thank you, Madam President.

THE CHAIR:

Will you remark further? Will you remark further?

Senator Kelly.

SENATOR KELLY:

Thank you, Madam President.

Through you to the proponent of the bill.

THE CHAIR:

Please precede, sir.

SENATOR KELLY:

I have a couple of questions. The first being, what is the actual definition of enrollee specific documents?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, I'm sorry, there was a noise, I couldn't hear the good senator's question.

THE CHAIR:

Can I ask that the people in the back of the Senate, please lower your voices, there's dialogue

going on between our two senators.

Senator Kelly, would you please repeat the question to Senator Crisco?

Thank you, SIR.

SENATOR KELLY:

Certainly, Madam President. What is the definition of enrollee specific documents?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Again I apologize Mr. -- Madam President, I still cannot hear the senator clearly.

THE CHAIR:

Senator Kelly, will you try it again, please.

SENATOR KELLY:

Okay.

What is the definition of enrollee specific documents?

THE CHAIR:

Senator Crisco, is that better?

SENATOR CRISCO:

Madam President, through you to the senator, I would assume that it's the insurance policy and any documents related to the appeal.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Okay.

What is the difference between Senate Bill 18 and Senate Bill 1158? They both appear to deal with the appeals review. Can you explain to me the difference?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, through you to the good senator, 1158, which will be in legislation that we are yet to consider requires specific documents while Senate Bill 19 requires all the documents.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you, Madam President and thank you, Senator Crisco.

I'm a little bit concerned with these two bills because I don't believe that Senate Bill 18 and Senate Bill 1158 actually mesh together. What we heard at Committee was reservations from the Connecticut Insurance Department who has submitted testimony and

expressed concern on the bill. Their remarks stated that the Federal Health and Human Services has indicated that our law does not conform to the newly revised NAIC model. Out State External Appeal Law needs to be amended in order to avoid a July 1, 2011 take-over by the Federal HHS of our external appeal program. As part of this process we also need to revise our Utilization Review Law. The proposed change in Senate Bill 18 is not consistent with the NAIC model and could be viewed as making our process noncompliant.

So, Senate Bill 18 has the propensity to make our current law non-compliant and yet we also have coming up Senate Bill 1158, which I believe is going to make our -- it's going to cause confusion in this area. Where when we look at the Federal Health Care Reform, what I believe one of the intentions of Federal Health Care Reform was to make the 50 states -- and 50 jurisdictions conforming, particularly where it comes into -- into the context of the exchange process. And what I think the adoption of Senate Bill 18 will do to Connecticut is make us once again not compliant. In other words, we're going to step out of line and -- and be an out liar if you will, when it comes to

health care reform.

So, I think the best -- what this is going to do if we adopt both Senate Bill 18 and Senate Bill 1158, is cause confusion at a time when health care reform is seeking uniformity.

For that reason I would oppose Senate Bill 18.

Thank you, Mr. President.

SENATOR DUFF OF THE 25TH IN THE CHAIR

THE CHAIR:

Thank you, Senator.

Will you remark further?

Senator Crisco.

SENATOR CRISCO:

Mr. President, I greatly appreciate and respect the senator's comments but I think -- you know, really, when you look at our history not only in health care but in environment we comply with the Federal Government and sometimes go beyond that. I think in this situation 1158, provides a floor and 18, provides additional steps to go a little higher.

Thank you, Madam(sic) President.

THE CHAIR:

Thank you, Senator.

Senator Prague.

SENATOR PRAGUE:

Thank you, Mr. President.

Through you to -- our question is to Senator Crisco.

THE CHAIR:

Please precede, madam.

SENATOR PRAGUE:

Thank you.

Senator Crisco, can I just get this straight? This bill is not going to affect the external appeal process?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam (sic) President, to you to Senator Prague, no.

SENATOR PRAGUE:

No. So the external appeal process will still be available to people when they're denied coverage. And in an appeal to the insurance company they're still denied coverage but then they can go to the department and have an external appeal.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

(Inaudible) to Senator Prague, that's right, but it also provides the individual with more documentation of their situation.

THE CHAIR:

Senator Prague.

SENATOR PRAGUE:

Thank you, Mr. President, through you to Senator Crisco, just to finalize this, which they can then use, Senator Crisco, in the external appeal process?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Mr. President, through to Senator Prague, as always, she's correct.

THE CHAIR:

Senator Prague.

SENATOR PRAGUE:

You heard that, Mr. President.

THE CHAIR:

So noted.

SENATOR PRAGUE:

Thank you, Senator Crisco.

THE CHAIR:

Will you remark, will you remark further on the bill?

Senator Crisco.

SENATOR CRISCO:

Mr. President, I believe Senator Kelly -- do you want a roll call vote?

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Mr. Clerk, please announce (inaudible) roll call vote.

THE CLERK:

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

THE CHAIR:

Senator Kissel. Have all members voted, if all members have voted, make sure your vote is accurately recorded. If all members have voted the machine will be closed. And the clerk will take the tally.

THE CLERK:

Mr. President --

Voting on Senate Bill Number 18

Total voting on	36
Those voting Yea	30
Those voting Nay	6
Absent and not voting	0

THE CHAIR:

The bill passes.

Mr. Clerk.

THE CLERK:

Mr. President, calling from Calendar page 33, Calendar Number 165, substitute for Senate Bill Number 923, AN ACT CONCERNING THE AMERICAN COLLEGE OF RADIOLOGY AND COLORECTAL CANCER SCREENING RECOMMENDATIONS. And the Clerk is in possession of amendments.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you, Mr. President.

Mr. President, I move for adoption of Joint Committee Senate Report and passage of the bill.

THE CHAIR:

On acceptance and passage, please precede, sir.

SENATOR CRISCO:

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VOL. 54
PART 22
6915-7208

back as amended by the House of Representatives. Just wanted to verify which -- it is on Agenda Number 2.

Thank you, Madam President.

From Agenda -- yeah, from Agenda Number 2, would like to place Calendar 115, Senate Bill 18 on the Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

Thank you. Thank you, Madam President.

Additional items to place on the second Consent Calendar, Madam President.

The first item appears on Calendar page 9, Calendar 473, House Bill 6514; would move to place that item on the Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

Thank you, Madam President.

Calendar page 19, Calendar 639, Senate Bill 6554; Madam President, move to place the item on the Consent Calendar.

THE CHAIR:

So ordered, sir.

It'd be placed on the Consent Calendar. Would ask the Clerk to call the second Consent Calendar.

THE CHAIR:

So ordered --

SENATOR LOONEY:

The third Consent --

THE CHAIR:

-- sir.

SENATOR LOONEY:

-- Calendar.

THE CLERK:

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

Madam President, the third Consent Calendar begins on Senate Agenda Number 6, substitute for House Bill 6399, and Calendar page 33, Calendar Number 387, substitute for Senate Bill 952.

The Senate is now voting by roll call on the third Consent Calendar. Will all Senators please return to the Chamber. The Senate is now voting by

roll on the third Consent Calendar. Will all Senators please return to the Chamber.

THE CHAIR:

The -- your machine is open.

Senator Hartley.

Senator Slossberg.

All members have now voted. All members have voted.

The machine will be closed.

Mr. Clerk, will you call the tally?

THE CLERK:

Motion is on adoption of Consent Calendar Number 3.

Total number voting	36
Those voting Yea	36
Those voting Nay	0
Those absent and not voting	0

THE CHAIR:

Consent's Calendar is called -- passed.

At this time, I'm going to appoint (inaudible) --

SENATOR LOONEY:

Madam President, if we might first, I'd like to move immediate transmittal to the House of any items acted upon this evening requiring additional action by