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CONNECTICUT
GENERAL ASSEMBLY
HOUSE

PROCEEDINGS
2012

VOL.55
PART 23
7514 - 7863

THE CLERK:

On page 26, Calendar 481, Substitute for Senate Bill Number 410, AN ACT CONCERNING ADVERSE DETERMINATION REVIEWS, favorable report by the Committee on Insurance.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Megna of the 97th, you have the floor, sir.

REP. MEGNA (97th):

Thank you, Mr. Speaker.

Mr. Speaker, I move acceptance of the joint committees' favorable report and passage of the bill in concurrence with the Senate.

DEPUTY SPEAKER ARESIMOWICZ:

The question is on acceptance of the joint committees' favorable report and passage of the bill in concurrence with Senate.

Will you remark, sir?

REP. MEGNA (97th):

Thank you, Mr. Speaker.

Mr. Speaker, the Clerk is in possession of a strike-all amendment, LCO 4138. I asked that it be called, and I be permitted to summarize.

DEPUTY SPEAKER ARESIMOWICZ:

Will the Clerk please call LCO Number 4138, which will be designated Senate Amendment Schedule "A."

THE CLERK:

LCO 4138, Senate "A" offered by Representative Megna, et al.

DEPUTY SPEAKER ARESIMOWICZ:

Representative seeks leave of the Chamber to summarize amendment.

Is there objection to summarization? Is there objection to summarization?

Hearing none, Representative Megna, please proceed, sir.

REP. MEGNA (97th):

Thank you, Mr. Speaker.

Mr. Speaker, when a commercial medical insurance company denies a coverage to a covered body, they are entitled to in appeal process. What this bill essentially does is empower that covered person by telling the insurer, upon request by the patient, to disclose any and all information that that insurer used to deny the coverage, to empower that patient during the appeals process and do it in timely manner.

With that, I move adoption of the amendment.

DEPUTY SPEAKER ARESIMOWICZ:

The question before the Chamber is on adoption of House Amendment Schedule -- Senate Amendment Schedule "A."

Will you remark further on the amendment? Will you remark further on the amendment?

If not, I will try your minds.

All those in favor, please signify by saying aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER ARESIMOWICZ:

Those opposed, nay.

The ayes have it.

The amendment adopted.

Will you remark further? Will you remark further?

Representative Megna.

REP. MEGNA (97th):

Thank you, Mr. Speaker.

Mr. Speaker, with no objection, I make a motion to move this to the consent calendar.

DEPUTY SPEAKER ARESIMOWICZ:

The motion before us is to place the item on the consent calendar.

Is there objection? Is there objection?

Hearing none, this item is placed on the consent calendar.

Will the Clerk please call Calendar 485?

THE CLERK:

On page 27, Calendar 485, Substitute for Senate Bill Number 31, AN ACT ESTABLISHING A COMMISSION ON JUDICIAL COMPENSATION, favorable report by the committee on Government Administration and Elections.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Fox of the 146th, you have the floor, sir.

REP. FOX (146th):

Thank you, Mr. Speaker.

I move for the acceptance of the joint committees' favorable report and passage of the bill.

DEPUTY SPEAKER ARESIMOWICZ:

The question is on acceptance of the joint committees' favorable report and passage of the bill.

Will you remark, sir?

REP. FOX (146th):

Thank you, Mr. Speaker.

What this bill does is it establishes a commission which will on a four-year basis go through a variety of criteria in order to make determinations

On page 7, Calendar 219, House Bill Number 5148, AN ACT CONCERNING AN ACT CONCERNING COMMUNICATIONS TO VICTIMS OF THE CURRENT OPERATION OF A MOTOR VEHICLE THAT RESULTS IN DEATH OR SERIOUS PHYSICAL INJURY.

DEPUTY SPEAKER ARESIMOWICZ:

The distinguished Majority Leader, Representative Sharkey.

REP. SHARKEY (88th):

Thank you, Mr. Speaker.

Good to see you up there.

DEPUTY SPEAKER ARESIMOWICZ:

Thank you, sir.

REP. SHARKEY (88th):

Mr. Speaker, this represents the consent calendar and for everyone's edification, I will be listing off the calendar numbers in numerical order so that everyone can follow. I'll try keep it -- and make sure that I do it in numerical order. Thank you.

These will be: Calendar Number 90, Number 155, Number 219, Number 223, Number 290, Number 320, Number 338, Number 345, Number 389, Number 430, Number 444, Number 455, Number 467, Number 470, Number 475, Number 481, Number 485, Number 488, Number 489, Number 494,

Number 496, Number 497, Number 505, Number 510, Number 513, Number 525, and Number 531.

I move adoption, I move adoption.

And with that, Mr. Speaker, I move adoption of the consent calendar. I move the consent calendar.

(Speaker Donovan in the Chair.)

SPEAKER DONOVAN:

The question before us is on passage of the bills on today's consent calendar.

Will you remark?

If not, staff and guests please come to the well the House. Members take their seats. The machine will be open.

THE CLERK:

The House of Representatives is voting by roll call. Members to the chamber. The House is voting today's consent calendar by roll call. Members to the chamber please.

SPEAKER DONOVAN:

Have all members voted? Have all members voted?

Please check the roll call board to make sure your vote has been properly cast.

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

The Clerk please announce the tally.

THE CLERK:

On today's consent calendar

Total number voting	144
Necessary for passage	73
Those voting Yea	144
Those voting Nay	0
Those absent and not voting	7

SPEAKER DONOVAN:

The consent calendar passes.

Any announcements or introductions? Any announcements or introductions?

Is there any business on the Clerk's desk?

THE CLERK:

A list of Senate bills, Mr. Speaker.

SPEAKER DONOVAN:

Representative Brendan Sharkey.

REP. SHARKEY (88th):

Thank you, Mr. Speaker.

I move that we waive -- waive the reading of the bills and have these items placed immediately on the House calendar.

STANDING COMMITTEE HEARINGS

INSURANCE AND REAL ESTATE PART 4 985 – 1325

2012

CHAIRMEN: Senator Crisco
Representative Megna

MEMBERS PRESENT:
SENATORS: Kelly

REPRESENTATIVES: Sampson, Aldarondo,
Altobello,
Crawford, D'Amelio,
Noujaim,
Sanchez, Schofield,
Yaccarino

SENATOR CRISCO: (Inaudible) the Real Estate Committee and we will proceed with the public hearing agenda and start with elected officials and call Senator Looney.

SENATOR LOONEY: Good afternoon, Senator Crisco and Representative Megna and distinguished members of the Insurance and Real Estate Committee. I'm Martin Looney, State Senator of the 11th District, New Haven and Hamden. I'm here to testify in support of Senate Bill 410, An Act Concerning Adverse Determination Reviews.

Senate Bill 410, and I'm very grateful for the Committee to having raised for this hearing, would create greater equity for patients who are denied services from managed care organizations, health insurers or utilization review companies by allowing patients access to the complete record in the case.

This is a simple matter of fairness since 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, drug or device is medically necessary.

In general the burden of proof in any case should be placed on the party who has the information. Here the party is the insurer -- here that party is the insurer which is the only party with knowledge as to why a claim was denied.

Ideally the burden of proof should be switched to create an assumption that medical treatments, drugs and devices that are ordered by a licensed provider are medically necessary and thus place the burden proof on its rightful place which is on the insurer that is denying coverage. However, since this change is unlikely at this time, we, at least, must allow the patients and providers the information they need to appropriately file an appeal.

Insurers are not always forthcoming with the complete records in the case and access to the record would offer the patient and the provider critical information as to how the decision to deny coverage was formulated and thus allow the patient and the provider to make the appropriate arguments on an appeal.

While requirements in the federal health reform bill, and the conforming changes made last year in Public Act 11-58, grant access to certain documents used by the insurers, it did not require that the patient be provided with all the documents in the case. Public Act 11-58 does meet the minimum requirements contained in the Patient Protection and Affordable Care Act but these requirements are -- are a floor rather than a ceiling and states are free to offer additional patient protections and we should.

This bill would require that the insurer provide all the information to the patient and provider. The patient and provider should not be left guessing as to the reasons for denial. This legislation would allow them a fair chance to present the counter-argument with access to all the appropriate information. It's simply a matter of fairness and equity. If the patient has the burden of proof, the patient must be given all of the available information to challenge a decision. Any other arrangement is untendable.

In cases where the denial of services in regard to a prescription drug, the bill would also 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.

I've experienced denials, have heard either directly or from constituents which were presented in a less than clear manner and one of these it turned out that somehow the pharmacy benefits manager had somehow erroneously transcribed my own date of birth and the -- just getting that straightened out took a good amount of time and a number of phone calls to clarify why there was a -- a glitch in coverage.

The -- the reason for the denials was not initially made clear and obviously I have skills and resources many of our constituents do not. I know of others, including Dina Berlyn, my legal counsel, who have faced even more complicated appeals and have not been able to acquire the complete records in -- in their cases as well.

This will -- this bill would do much to level the playing field on the issue of adverse determination reviews because so much is at stake for the patient in this process.

Again thank you for raising this important bill which would assist patients in our healthcare system and provide much greater equity.

Thank you, Mr. Chairman.

SENATOR CRISCO: Thank you, Mr. Looney. I'm -- I'm glad they corrected your date of birth because you would have been too young to run for office.

Any other questions?

Thank you very much, sir.

SENATOR LOONEY: Thank you very much and again it's -- it's a pleasure to appear before this Committee that does so much valuable and important work for our state.

SENATOR CRISCO: Thank you (inaudible) appreciate that.

Representative Perillo.

REP. PERILLO: Senator Crisco, Representative Megna, Senator Kelly, thank you very much for the opportunity to testify today on behalf of the House Republican Caucus on House Bill 5485, An Act Concerning the Health -- the Connecticut Health Insurance Exchange.

Despite many misgivings members of our caucus have about the Affordable Care Act, we have

plan and the establishment of the essential health benefits has tremendous fiscal impact on the State of Connecticut. That -- that defined essential health benefit will really drive the cost for the entire state. When you're talking about numbers of that magnitude, it really is essential to this Committee and the Assembly, as a whole, have an opportunity to weigh in and determine what the best choice is because, as I said, it does have such a tremendous financial impact.

REP. MEGNA: Thank you, good answer.

Thank you, Mr. Chairman.

SENATOR CRISCO: Thank you.

Any other questions?

Thank you, Representative, we really appreciate your comments and we will, you know, review them.

Thank you very much.

REP. PERILLO: Thank you very much.

SENATOR CRISCO: Proceeding along to healthcare advocate Veltri.

HB5485

VICTORIA VELTRI: Good afternoon, Senator Crisco, Representative Megna, Senator Kelly. I'm Vicki Veltri. I'm the state healthcare advocate and I'm actually here to testify on Raised Bill 410. I won't repeat my testimony since you have it there.

I think this bill is important because it points out the continued barriers that consumers face when they go to appeal denials

of their insurance claims. And specifically when I -- when I refer to the big problems, I'm talking about people who have been denied something for lack of medical necessity.

It's very difficult to put an appeal together to challenge an insurance company's denial of care. That's what my office does. We've done about 5,000 of them last year. If it were easy our office wouldn't need to exist.

The bill that passed last year which was based, in part, on the changes to the internal and external review processes by the federal government, was a good step and clearly compliant with federal law but is missing a couple of pieces and, as a matter of illustration, I'd like to tell you for instance an example about this requirement that the carriers must provide any additional clinical rationale they used in their benefit determination denials to a consumer prior to making a final decision so the consumer has that information available to them to -- to rebut the insurer's statements or -- of their peer reviewer's rationale.

Well we haven't been getting that information. The carriers are not providing it in all cases. We've really had to demand it in almost every case we've appealed. It's -- it's not forthcoming as the law would suggest. And without that clinical rationale, it's impossible to make a complete case.

For instance you could have a situation where you're at a carrier's location for an appeal, they bring a peer reviewer in to sit at the appeal, and that peer reviewer happens to be a clinician. If you don't have access to that clinician's opinion and information they

provided to the peer panule -- excuse me -- peer review panel when they've made their decision, you're missing a huge piece that you need if you're going to appeal that case.

So I guess what I'm suggesting is the language of 410 may not be perfect. I think it's a step in the right direction and I'd like to offer some assistance to the Committee in drafting some language that could be maybe a little narrower but address the actual problem at hand.

And I'd like to also add I know a lot of people will -- many of the carriers will say well we have this great external peel -- review process in Connecticut. It's the -- you know the people around the country love our external appeal process. It's true we have a great external appeal process but the external appeal process is not a substitute for the internal appeal process and should only have to be used when an internal appeal process does not work. So let's fix the internal review process.

And if I may I -- I'd like to ask Senator Crisco if he would give me just a minute to address Representative Perillo's testimony on 5485 even though we've submitted testimony on this bill. I wondered if he would give me just a second to clarify a couple of things.

SENATOR CRISCO: Please, you know, submit, you know, your -- your opinion (inaudible).

VICTORIA VELTRI: Yes. Well first I just want to make clear that I know Representative Perillo alluded to an Exchange draft report that the board put up in February. Actually that report was not a report of the board and was -

advocate to see if there's anything that can be done within their insurance policy. And we have about 3,400 children in the state with arthritis who use these medications as well as a percentage of 739,000 adults. Our total number of arthritis is about a quarter of the state's adult population.

So I hope that helps.

REP. MEGNA: It's enlightening. Thank you very much.

SENATOR CRISCO: Any questions? Any questions?

Thank you so much.

We will proceed to Senate Bill 410.

Susan Halpin, Susan sure you want to do this?

SUSAN J. HALPIN: Good afternoon, Senator Crisco, Representative Megna, Senator Kelly, Representative Schofield. For the record I'm Susan Halpin. I'm here on behalf of the Connecticut Association of Health Plans to offer testimony in opposition to Senate Bill 410, An Act Concerning Adverse Determination Reviews.

As you've heard earlier Connecticut has already taken significant action in the area of adverse determinations. Our external appeal process is held up as a model around the country and just last year you enacted laws that already required that a covered person receive from a carrier, free of charge and upon request, reasonable access to copies of all documents, records and other information relevant to an adverse determination under review.

The bill before you would require, with every notice of appeal, an upheld adverse determination or copy of all documents, communications, information and rationale regarding the adverse determination regardless of whether the member requests such information and regardless of whether such information was considered by the health plan in making the decision.

Further Senate Bill 410 requires that, upon denial and subsequent appeal for prescription drugs, that health plans be required to provide authorization and payment to such covered person's pharmacy for the drug for the duration of any grievance or review.

We believe there are serious implications for safety if, in fact, this provision were implemented. Think about controlled substances. A person may be guaranteed access to and payment for oxycontin, for example, provided they presented with a script. The same would be true if the drug were denied for a potential drug interaction or other clinical reason; if it were experimental.

We believe that this provision would not only add enormous pharmacy -- cost to pharmacy benefits but would also give rise to serious safety considerations and we would strongly urge your rejection of Senate Bill 410.

SENATOR CRISCO: Let's see -- Susan would your Association consider any different language, modification of the language? You don't have to answer that. You could check that out and -- and let us know. You've heard the previous testimony.

Representative Schofield.

REP. SCHOFIELD: Thank you, Mr. Chairman.

Yeah I -- I guess I would want to ask you if -- if you can respond to what Vicki Veltri had to say that companies are not making the information available and -- and maybe refresh my memory a little bit. I thought I recalled a -- an old law or last year's law as requiring that when a denial is sent that at least some basic information is provided about the basis for that denial. Is that right?

SUSAN J. HALPIN: I -- I believe it's upon request that we provide some basis. There -- you know there are -- there are, as I understand it, certain things that are said but to -- to request the background information in other words that's upon request.

REP. SCHOFIELD: Yeah I mean I can see that it's very expensive to send reams of --

SUSAN J. HALPIN: Yes.

REP. SCHOFIELD: -- copies of medical studies every time you've denied something. But do -- when -- when a denial is made, do you at least say in there that it's denied because we didn't feel this was a, you know, a valid diagnosis or that this treatment is experimental or, you know, some kind of a reason like that?

SUSAN J. HALPIN: Yes that's usually the -- the case that your -- your -- there's an explanation.

REP. SCHOFIELD: Or if it's excluded then there's some -- some kind of explanation there already.

SUSAN J. HALPIN: Right, right, right. And I -- I did hear the testimony earlier and I'm happy to look into it. You know if the plan is not responding, you know, it's difficult to answer anecdotes in a forum such as this but obviously we'd be happy to look into that.

REP. SCHOFIELD: Yeah, okay, thank you.

SENATOR CRISCO: Thank you.

Any other questions?

Thank you very much, Susan.

SUSAN J. HALPIN: Thank you.

SENATOR CRISCO: The other Susan, yeah? Thank you. Susan too.

SUSAN RAIMONDO: Good afternoon, gentlemen and ladies and distinguished members of the Insurance Committee. My name is Susan Raimondo. The National MS Society we're requesting that you pass Senate Bill 410, An Act Concerning Adverse Determination Reviews.

People with MS experience a variety of complex medical symptoms and problems that can lead to significant disabilities. It's a chronic disease and again symptoms can be very mild or very severe. People need -- with MS -- living with MS need to have access to chronic disease management, rehabilitative services and devices, mental health and prescription drugs.

All of these services are subject to frequent denials by health insurance providers. Senate Bill 410 would create a greater equity for patients who are denied services from health

plans because it allows a patient access to the complete record in their appeal. This legislation provides a tool for the beneficiary and his or her health professionals to have all of the information that was used to deny the benefit.

The bill would also require that the insurer provide the patient with the denied medication during the course of the appeal. This protects the patient by giving him or her access to the needed medication and encourages the insurer to resolve the case faster.

Currently when a health plan denies coverage, the burden of medical necessity rests on the patient and the provider. The fact that the health plan must provide the entire record is a simple matter of fairness to the patient and the provider.

We are urging you to pass Senate Bill 410, An Act Concerning Adverse Determination Reviews. We thank you for recognizing the importance of this bill and this bill will assist individuals in maximizing their health and wellness.

SENATOR CRISCO: Thank you, Susan.

Are there any questions for Susan?

Yes, Representative Schofield.

REP. SCHOFIELD: Thank you.

And you for your prior -- predecessor's comments too.

SUSAN RAIMONDO: Yes.

REP. SCHOFIELD: And you know it does trouble me the notion that you're expecting a company to provide not only the -- the material that they used in making the decision but material that they didn't use in making a decision. Can you help me understand that? That's kind of a strange thing to ask for.

SUSAN RAIMONDO: Well I -- I guess and -- and maybe I -- I didn't word it --

REP. SCHOFIELD: All comments, documents, recommended -- records and other information whether or not used by the company. I mean that could mean they'd be sending --

SUSAN RAIMONDO: I agree.

REP. SCHOFIELD: -- every person --

SUSAN RAIMONDO: I agree.

REP. SCHOFIELD: -- reams and reams of information.

SUSAN RAIMONDO: That -- I mean clearly I can --

REP. SCHOFIELD: Killing trees.

SUSAN RAIMONDO: Well I'm not for killing trees. What I do think is that we often hear from individuals who are given almost no information at all about the denial and the reason for the denial and so often we see people that just give up and they don't appeal. And although we, as a national organization, provide resources in terms of information about the types of medical literature out there that can be helpful to a person in dealing with these types of denials, we still see situations where it's not enough.

And frankly it's -- it's everything from clogging up the system to issuing situations where people, you know -- our population suffers from many different aspects of -- of illness. Many of our people have cognitive impairment. They have visual impairment and, you know, I think that -- and I -- I would, you know, -- I would be happy to talk further with some of our volunteers about the -- the legal aspects of what you're asking for. I certainly can go back to my -- our volunteers and try to do that.

I think from the perspective of physicians that are caring for people with MS, the -- I think one of the things that we see in MS is often the types of -- of literature that's out there or information that's out there. You know there's some of it but there's not a lot of it. And often with a complex illness, like MS or some of the other illnesses out there, even mental health conditions, many things are used based on the physician's experience and when the physician has used something for -- for many people and you're living with a chronic illness and you -- you need hope.

And, you know, personally my husband, he's a Medicare patient, but we've exhausted every single medication for him. His physician has presented academic papers, poster papers, things like that, on a -- on the treatment that he's using for people with MS. We haven't started it yet. We're considering it. But that is -- is not necessarily -- you know you're not going to find that in every single piece of literature about MS.

So that might be an example where I think flexibility in terms of the sources and information and -- and really working together

with the professional, the patient and, you know, having -- having access to the information and -- and, in some ways, why, you know -- and I -- again I -- I'm happy to go back and -- and talk with our volunteers but I think -- I think the reality of -- of giving people open access to it is critical. Really I mean for transparency.

Thank you.

SENATOR CRISCO: Thank you.

Any other questions?

Yes, Representative Altobello. No? Okay.

A VOICE: (Inaudible).

SENATOR CRISCO: The young lady. She's a beautiful lady.

Any other questions?

Thank you so much, Susan.

SUSAN RAIMONDO: Thank you.

SENATOR CRISCO: Is there any other testimony? Anybody else who would like to testify?

Yes.

A VOICE: (Inaudible).

SENATOR CRISCO: No please come to the microphone. Just identify yourself and we'll go from there.

You weren't here earlier.

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FTR

March 15, 2012

Good afternoon Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee. I am here to testify in support of SB 410, AN ACT CONCERNING ADVERSE DETERMINATION REVIEWS.

Most unfortunately, I have experienced first hand the appeals process for healthcare coverage denials. This experience is why I believe that SB 410, 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. One might think that the insurer, pharmacy benefits manager, or utilization review organization should at least tell the patient when they deny a claim but apparently this is not true.

Once it became clear that my doctor had renewed the prescription appropriately (a fact that I had to track down) 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 (as well as for any information) but NEVER received them. I did receive a fax which started at page 52 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). What were they hiding in the prior 51 pages? Apparently I will never know.

Once the internal rounds of appeal 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 any evidence I could find (nor would they provide evidence to me). Unfortunately, there was no requirement that Caremark provide me with the supposed evidence that they were using to make these claims. I had to make the best case I could for the use of this drug for my condition without any knowledge of what Caremark's case against me was.

Once the Department of Insurance receives an external appeal, it sends the appeal out to the 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, they would not be able to deny others with a prescription for the same drug for this condition. 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 a perfect world, the insurers would carry the burden of proof. They have the information and in general at law, the burden of proof is placed on the party with the information. However, since it seems unlikely that the burden of proof will be shifted, the patient MUST be granted access to all the information related to the case.

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 and prevent insurers from substituting their judgment for that of the skilled medical professional.

While PA 11-58 did make significant reforms to the appeals process such that the process in Connecticut meets the minimum requirements under the federal Patient Protection and Affordable Care Act we can and should do more. These federal requirements are meant to be a floor; the states are free (perhaps encouraged) to offer additional protections to patients. The State of Connecticut should offer its citizens the additional protections provided by this bill.

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

I am including a copy of my appeal letter as well as of the letters that I received from Caremark. If you are interested in viewing the journal articles that I cite in my appeal, I would be happy to share those with you. What is also extraordinarily disturbing in the letters from Caremark is that some of the letters claim erroneously that the prescriptions was for "cognitive dysfunction." The prescription was for fatigue related to multiple sclerosis (the most common symptom of this disease). I do not have nor have I ever had cognitive dysfunction; I have reviewed all of the medical records from my doctor and cognitive dysfunction is NEVER mentioned. I find this unacceptable and disturbing. Caremark denied coverage based on inaccurate information that they created.

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Connecticut Insurance Department
P.O. Box 816
Hartford, CT 06142-0816
Attn: External Appeals

May 28, 2009

Dear Gentlepersons:

This letter is my appeal of the denial of coverage for Provigil which I was prescribed for multiple sclerosis related fatigue.

Facts of my case

1. I am a patient with multiple sclerosis. I was diagnosed in 1997.

2. I have suffered from fatigue. Fatigue is the most common (and perhaps most debilitating) symptom of MS.

3. I had tried Amantidine but it did not work all that well and it appeared to contribute to a concerning increase in my liver enzymes in 2003 (ALT and AST about 3x normal).

4. I was prescribed Provigil (modafinil) beginning in 2004. It worked extremely well. It is **medically necessary**. Clearly there is sufficient evidence as to the effectiveness of Provigil. There is "credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community" and it is "consistent in policy issues involving clinical judgment" as Sec. 38a-513c requires.

5. There is substantial evidence that provigil is effective. I have attached copies of journal articles, the letter to Caremark from my doctor, my letters to Caremark, and Caremark's letters to me.

6. I have been on provigil for approximately 5 years and then suddenly for some reason Caremark decided to deny prior authorization. **I HAVE REQUESTED THAT CAREMARK SEND ME THE COMPLETE RECORD OF MY CASE. I MADE THIS REQUEST ON APRIL 16 AND HAVE NOT YET SEEN THE RECORD.** It

is difficult to fight this denial of coverage when Caremark refuses to provide me with information as to why the coverage was denied.

In response to my April request for the full record, I got a phone call on May 26, 2009 asking me if I had received a package they claimed to have sent on May 18. I had not received this package. They then said they would overnight another copy. What appeared the next day was a letter (attached) with an additional copy of the Insurance Department's external appeal form. Although the letter said the record of my case would be enclosed it was not. The letter was dated May 18 but the fax was dated April 17. I have enclosed these items. The fax indicates that the form is pages 52-60. Pages 1-51 appear to be missing.

7. I lost on both rounds of the internal appeals process at Caremark DESPITE convincing evidence as to the effectiveness and **medical necessity** of provigil in my case provided by both my healthcare provider, Dr. Jana Preiningerova (who specializes in treating MS patients) and me.

8. Caremark has made inaccurate assertions in regard to the evidence of the efficacy of Provigil:

In its letter of April 14, 2009 Caremark asserts that "the only peer reviewed study in the literature finds provigil to be of no value for MS fatigue." This is untrue. I have included three journal articles that do in fact find that Provigil is significantly helpful for MS patients with fatigue:

a. *Modafinil effects in multiple sclerosis patients with fatigue*. J Neurol. 2009 Apr;256(4):645-50. Epub 2009 Apr 9. Lange R, Volkmer M, Heesen C, Liepert J showed that Modafinil (as compared with placebo) improved fatigue, focused attention and dexterity and enhanced motor cortex excitability.

b Efficacy and safety or modafinil (Provigil) for the treatment of fatigue in multiple sclerosis: a two centre phase 2 study by Rammohan, Rosenberg, Lynn, Blumenfeld, Pollak and Nagaraja in J. Neurol Neurosurg Psychiatry, 2002 Feb; 72(2): 179-83 demonstrated that a 200 mg per day dose of modafinil significantly improves fatigue in MS patients while a 400 mg per day dose does not.

c. In addition, *Modafinil in treatment of fatigue in multiple sclerosis. Results of an open-label study* by Zifko, Rupp, Schwarz, Zipko, and Maida in J. Neurology also found that a 200 mg per day dose of modafinil significantly improves fatigue and sleepiness and is well tolerated by patients with MS.

Caremark makes a claim that in the only peer reviewed journal article no effect was shown on fatigue in MS. As you can see above there are at least three peer reviewed journal articles that show significant effect.

I have also included citations to articles showing the effectiveness of Provigil on other MS symptoms.

9. Despite my repeated requests, Caremark has chosen not to disclose the citation of the journal article that it claims showed no effect. However, I assume it is Stankoff, et. al. (2005). A closer examination of this article shows that the study used a **non-standard dose and a non-standard dosing schedule** (see attached response to Stankoff). Usually, MS patients are given Provigil in a single dose first thing in the morning. In the Stankoff study patients were given one dose in the morning and one dose at mid-day. Since Provigil has a 15 hour mode of action, it is quite possible (even probable) that a mid-day dose could interfere with a patient's sleep thus destroying any positive effect that the drug had on fatigue. In addition, the Rammohan study showed that 200mg was more effective than 400mg for MS patient' with fatigue but the Stankoff study dosed at 400 mg.

Provigil allows me to remain employed. Prior to my taking this drug is was very difficult for me to function in the afternoon at work. It is clear that Provigil is effective in my case. Provigil is medically necessary for me if I am to continue to function at my current level.

a. My job as Counsel and Executive Aide to the Majority Leader of the State Senate requires that I be alert with a crisp mind at all times. Provigil allows me to do my job and thus is medically necessary.

b. Although my job is not technically "shift work" it does have certain similar properties. There are days in which I am required to work very late into the night and then be back at work the next morning. This would not be possible without the assistance of Provigil.

I ask that you overturn Caremark's decision to deny me access to a medically necessary drug which allows me to live my life and contribute to society. Clearly there is sufficient evidence as to the effectiveness of Provigil. **There is "credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community" and it is "consistent in policy issues involving clinical judgment" as Sec. 38a-513c requires.**

The fact that there are differing reports in academic literature makes it all the more important that this decision be left to the judgment of the treating physician. Please note that the one article that found that Provigil was not effective in MS had flawed methodology and a small sample size. MS is a very individual disease; no two of us

have exactly the same disease. Physicians who specialize in treating MS patients are the ones who are best able to make decisions as to which drugs are medically necessary for their patients. Please help me continue to be a productive member of society.

Thank you,

Dina B. Berlyn, Esq.

Attachments:

Letter to CVS from Dr. Preiningerova
Letter from Senator Looney
Letter from Dina Berlyn to CVS
CVS letters to Dina Berlyn dated 3/16, 3/19, 4/3, 4/9, 4/14
Email correspondence with CVS
CVS letter dated May 18 with fax of Ins. Dept. forms
Journal Articles: Lange et.al.; Rammohan, et al; Zifko, et al; response to Stankoff.
CGS 38a-513c

Provigil effectiveness on other MS symptoms

Modafinil improves primary nocturnal enuresis in multiple sclerosis.
Carrieri PB, de Leva MF, Carrieri M, Buongiorno M.
Eur J Neurol. 2007 Mar;14(3):e1. No abstract available.

ECTRIMS: Thursday, September 28, 2006, 15:30 - 17:00
Final analysis of combination therapy (Provigil® + Avonex®) in the treatment of cognitive problems in patients with relapsing-remitting multiple sclerosis
J.A. Wilken, M.T. Wallin, C.L. Sullivan, R.L. Kane, H. Rossman, S. Lawson, J. Simsarian, C. Saunders, R. Shin, J. Mikszewski, D. Kerr, M.E. Quig
(Washington, Baltimore, Farmington Hills, Fairfax, Arlington, USA)

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Consumer Services Division
Phone: 860.297.3900, Ext. 3945
Fax: 860.297.3872
cid.ea@ct.gov

June 1, 2009

Dina B. Berlyn
30 Morris Street
Hamden, CT 06517

Re: ***Request for External Appeal Review***
Department File: ER2009-110
Applicant: Dina B. Berlyn

Dear Ms. Berlyn:

During the process of setting up your external appeal, CVS Caremark notified our Department that your prescription for Provigil will be covered.

Your external appeal will be withdrawn and your $25 fee returned under separate cover.

Sincerely,

Wendy Manemeit

Wendy P Manemeit
Associate Examiner

Enclosure(s)

CVS CAREMARK | 2211 Sanders Road | Northbrook, Illinois 60062

May 18, 2009

Ms. Dina Berlyn
30 Morris St.
Hamden CT 06517

was not included. all I got was this fax starting @ P52

Dear Ms. Berlyn;

CVS Caremark administers the prescription portion of the State of Connecticut health plan. In response to your request attached, please find copies of our file regarding your request for coverage for Provigil®.

Included in the attachment is the review of coverage performed by third party independent vendor; Medical Review Institute of America. The independent reviewer is a physician who is board certified by the American Board of Psychiatry and Neurology on Neurology and member of the American Academy of Neurology.

Your letter indicates your disagreement with this coverage decision. Therefore we recommend that in compliance with the terms of your benefit plan, an appeal is filed with the Connecticut Department of Insurance, if you haven't done so already.

We are sorry for the inconvenience that you have experienced when discussing your prescription coverage with our Customer Service Representatives. Our goal is to provide you with the level of service that exceeds your expectations and in this case, we clearly did not do that.

Should you have any additional questions regarding your Provigil prescription coverage, please contact our Service Recovery Team at: 1-800-749-6199 ext. 6822.

Sincerely,

Lynne Anderson
Director, Operations Excellence
Service Recovery Unit

CC: MRIOA File- April 8, 2009

Connecticut Insurance Department

External Appeal Consumer Guide

Connecticut General Statute 38a-478n gives you the right, under specific circumstances, to an external appeal for coverage of medical services or supplies denied to you by your health plan. Coverages may have been denied through a process known as utilization review or after retrospective review of a claim submission.

To understand how the external appeal process works, you should first have an understanding of what is meant by "utilization review" and "retrospective claims denial".

UTILIZATION REVIEW

Utilization review (UR) is the prospective or concurrent assessment and decision-making process used to determine the medical necessity of a medical treatment or service. This does not include a denial of a claim for which prior approval was not required. Utilization review may be performed by your health plan or an independent utilization review company on behalf of your health plan.

Each health plan determines which services are subject to utilization review. Examples of medical treatments or services commonly subject to UR include, but are not limited to:

- Hospitalization, including length of hospital stay;
- Surgery;
- Mental health & substance abuse;
- Specialist referrals;
- Outpatient services, such as physical therapy.

Depending on your contract, you or your provider will contact your health plan or the UR company acting on behalf of your health plan, to request authorization for a specific service or treatment. Based on information submitted by your provider, the UR contact will assess the medical necessity of the proposed treatment and either authorizes or denies coverage for the requested treatment.

RETROSPECTIVE CLAIMS DENIAL

Retrospective claims denial is when a service that was not subject to prior approval is denied as not "medically necessary" when the claim is submitted.

INTERNAL APPEAL FOR A DENIED MEDICAL TREATMENT OR SERVICE

Every health plan has appeal procedures. When you are denied coverage for a medical treatment or service, you may appeal the decision to your health plan or UR company acting on behalf of your health plan. This appeal is known as the "internal appeal." Many plans have more than one level of internal appeal. Consult your employer or coverage documents to find out how to make an appeal.

ELIGIBILITY FOR EXTERNAL APPEAL

To be eligible for the external appeal process through the State of Connecticut Insurance Department, you must satisfy the following requirements:

- **You must have exhausted the internal appeal procedures of your health plan.**

Your health plan or utilization review company acting on behalf of your health plan is required to provide you with written notification that you have exhausted the internal appeal process.

- **Your completed "Request for External Appeal" form must be received by the Insurance Department within 60 days of receiving the written notification that the internal appeals have been exhausted.**

For purposes of this process, the number of days is based on calendar not business days. The 60 day time frame will commence 7 days after the date on the final denial letter, unless other evidence of a later receipt date is provided. Once this 60 day period expires, you will not be eligible for the external appeal process.

***Please note:** You may have a pending complaint filed with the Consumer Affairs Division of the Insurance Department concerning your health care benefits. This does **not** constitute a request for an external appeal. You must file for a separate external appeal on the request form and follow the guidelines provided in this brochure.

- **You must be actively enrolled in a health care plan at the time the service was requested as well as when the service is provided.**

- **External appeal is only for a service or procedure that is covered in your contract.**

You may only use this external appeal process to appeal for services that are covered in your contract. The appeal process cannot be used to expand the coverage of your contract. For example, this process cannot be used to authorize coverages that are exclusions in your contract. Be sure to review the listed exclusions in your contract.

- **The denial of medical treatment or services must be based on "medical necessity."**

- **Your appeal cannot be for workers' compensation claims.**

- **Your health plan cannot be a non-governmental "self-insured" plan.**

Your employer can tell you if your plan is "self-insured." The Insurance Department has no jurisdiction over "self insured" plans. The Insurance Department's Consumer Affairs Division (1-800-203-3447) can direct you to the appropriate agency for assistance.

- **Your health plan cannot be offered as part of a Medicaid, Medicare or a Medicare Risk program.**

FILING THE EXTERNAL APPEAL

You, or your provider with your written consent, may request an external appeal. The "Request for External Appeal" and all supporting documents for the external appeal must be received by the Insurance Department within 60 calendar days of receiving the final denial letter. **The following items must be included in your**

appeal. Your appeal will be rejected if all of these items are not included:

1. The ***non-refundable*** filing fee of $25 (Please make check or money order payable to: *Treasurer-State of Connecticut).*

Note: The fee will be waived by the Insurance Commissioner for indigent individuals or those unable to pay. Indigent individual means an individual whose adjusted gross income (AGI) for the individual and spouse, as certified on the request form, from the most recent federal tax return filed, is less than two hundred percent of the federal tax poverty level. Table 1 (below) lists the 2007 poverty levels. If your AGI is below the figure corresponding the number of members in your family*, then the $25 fee will be waived.

Table 1

Number of Family Members	200% of 2007 Federal Poverty Level
1	$20,410
2	$27,380
3	$34,340
4	$41,300
5	$48,260
6	$55,220
7	$62,180
8	$69,140

*Add $6,960 for each additional family member.

2. Evidence of being an enrollee of the plan (photocopy of your insurance card).

3. A copy of the letter from your health plan or UR company acting on behalf of your health plan indicating that all internal appeal mechanisms have been exhausted.

4. A completed "Request for External Appeal" form that includes a **medical release** signed by the patient (on page 2 of the "Request" form.) You may contact the Insurance Department for copies of the form or download it from the Department's website.

6. Proof that the service in question is a covered benefit. This is typically a copy of your **entire** policy handbook or certificate of coverage that details all benefits and provisions. A summary of benefits is not acceptable. If you do not have a copy of your policy, your health plan can provide one to you with your written request. When you e-mail or write to your health plan for a copy of your policy booklet or certificate of coverage, they are required to provide it to you within five (5) business days of receiving your request. If you belong to a self-insured governmental plan, contact your employer. In lieu of the actual handbook or certificate of coverage, the health plan may send a letter certifying that the service is a covered benefit or send detailed instructions on how to access the handbook or certificate of coverage electronically.

Note: If you are close to the 60 day deadline for submitting your external appeal application and have requested a copy of your handbook or certificate of coverage from your health plan but have not yet received it, **DO NOT DELAY** in sending the "Request for External Appeal" form and all other attachments to the Insurance Department. In lieu of the proof the service is covered, attach a copy of your dated written letter or e-mail to the health plan requesting the handbook or certificate of coverage. This must be submitted with your "Request" form so that your request will not be rejected by the External Appeal entity as incomplete. If the health plan fails to provide the required proof within 5 days,

the external appeal entity will make the presumption that the service is covered. As stated earlier, this presumption of coverage is for purposes of continuing the external appeal process and does not guarantee payment of the service.

THE APPEAL PROCESS

The Insurance Department contracts with independent entities to review the appeal. Once a complete application is received, the Insurance Commissioner will assign the appeal to an external entity for review. The entity will conduct a preliminary review to determine the eligibility of the appeal. If your appeal does not meet the conditions described in the "Eligibility for External Appeal" portion of this brochure, your appeal will be ruled ineligible. The external appeal entity will contact you and the Insurance Commissioner within 5 business days of its receipt, as to whether the appeal has been accepted or denied for full review. If the appeal is rejected in the preliminary phase, the external appeal process ends.

If the appeal is accepted, the reviewing entity will complete the full review and forward its decision to the Insurance Commissioner within 30 business days of completing the preliminary review. The Insurance Commissioner shall accept the decision of the external appeal entity and notify you or your doctor and the health plan or the UR company.

MAILING INSTRUCTIONS

Please mail your application for external review to:

Connecticut Insurance Department
P.O. Box 816
Hartford, CT 06142-0816

Attn: External Appeals

For overnight delivery only, please send your application for external review to:

Connecticut Insurance Department
153 Market Street, 7th Floor
Hartford, CT 06103

Attn: External Appeals

Please call (860) 297-3910 for additional copies of this brochure, or with any questions or concerns that you may have. This External Appeal Consumer Guide and the External Appeal Request form are also available on the State of Connecticut Insurance Department's web site: http://www.ct.gov/cid

GLOSSARY

A **Health Plan** is a Managed Care Organization or an insurance company from which you or your employer contracted health benefits.

A **Managed Care Organization** is an insurer, a health care center (HMO), or other entity that issues coverage through a managed care plan.

A **Managed Care Plan** is a product offered by a managed care organization that utilizes a network of providers and includes utilization review.

Medical Necessity refers to the medical appropriateness of health care services that are needed to meet basic health care needs, consistent with diagnosis of condition and rendered in a cost-effective manner, and consistent with the national medical practice guidelines regarding type, frequency and duration of treatment.

Utilization Review (UR) is the prospective or concurrent assessment and decision making process used to determine the necessity and appropriateness of the allocation of health care resources provided to or proposed to be given to an insured under a managed care plan.

Revised 6/13/2007

STATE OF CONNECTICUT – INSURANCE DEPARTMENT
REQUEST FOR EXTERNAL APPEAL

Return to:

• P.O. Box 816 • Hartford, CT 06142-0816
• 153 Market Street • Hartford, CT 06103 (OVERNIGHT MAIL ONLY)
•(860) 297-3910

APPLICANT NAME _____ ☐ Enrollee/Patient ☐ Provider

ENROLLEE INFORMATION

Enrollee Name: _____ Patient Name: _____

Address: _____

_____

Enrollee Phone #: Home ( ) _____ Work ( ) _____

Enrollee Insurance ID #: _____

Insurance Claim/Reference #: _____

PROVIDER INFORMATION

Health Care Provider: _____

Address: _____

_____

Contact Person: _____ Phone: ( ) _____

Medical Record #: _____

HEALTH PLAN (Managed Care Organization or Insurance Company)

Managed Care Organization: _____

Address: _____

_____

Contact Person: _____ Phone: ( ) _____

UTILIZATION REVIEW COMPANY (If different than the Health plan)

Utilization Review Company: _____

Address: _____

_____

Contact Person: _____ Phone: ( ) _____

***** PLEASE COMPLETE ALL PAGES OF THIS FORM ***** revised 6/13/2007

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.
91-15458d

Enrollee/Patient Name: _____ Enrollee Insurance ID #: _____

DESCRIBE IN DETAIL THE DISAGREEMENT WITH THE HEALTH PLAN. INDICATE CLEARLY THE SERVICE(S) BEING DENIED AND THE SPECIFIC DATE(S) BEING DENIED. ATTACH ADDITIONAL PAGES IF NECESSARY AND INCLUDE PERTINENT MEDICAL RECORDS, IF AVAILABLE.

_____

_____

_____

PLEASE CHECK BELOW (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL FIVE (5) ITEMS BELOW ARE INCLUDED*)

1. ☐ **YES**, I have enclosed a **NON-REFUNDABLE** check or money order for $25 (Make payable to: Treasurer, State of Connecticut). [The filing fee will be waived for indigent individuals. Please see below, "Waiver of Filing Fee"];
2. ☐ **YES**, I have included a photocopy of my insurance identification card;
3. ☐ **YES**, I have enclosed the letter from my health plan or utilization review company that states that their decision is final and that I have exhausted all internal appeal procedures;
4. ☐ **YES**, I have executed the release of medical records [Please see below]. Dependent applicants (18 years and older) are responsible for signing the medical release form.
5. ☐ **YES**, I have enclosed proof that the service in question is a covered benefit. ***Please check one of the following:***

   ☐ A copy of my entire insurance policy benefit handbook or certificate of coverage, that defines all benefits and provisions with my health plan (Summary of Benefits is not acceptable) , **OR,**

   ☐ A copy of instructions from the health plan on how to access an electronic version of the policy benefit handbook or certificate of coverage, **OR,**

   ☐ A copy of a letter from the health plan certifying the service is a covered benefit, **OR,**

   ☐ I have requested a copy* of my handbook/certificate of coverage from my health plan and have not yet received a response. Attached is a dated copy of the letter or e-mail requesting my handbook or certificate of coverage.

[If you do not have a Handbook or Certificate of Coverage, write or e-mail your health plan for a copy immediately. DO NOT DELAY. If you do not receive these documents prior to your 60 day deadline to submit this request, send this Request for External Appeal to the Insurance Department before the 60 calendar days expire. A copy of your written request to the heath plan for the Benefit Handbook/Certificate of Coverage must be submitted with this Request for External Appeal.]*

***** PLEASE COMPLETE ALL PAGES OF THIS FORM ***** revised 6/13/2007

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.
91-15458d

REQUEST FOR EXTERNAL APPEAL AND RELEASE OF MEDICAL RECORDS

I, _____ hereby authorize the release of medical records necessary for the external review. I understand that these records may be obtained from the Health plan, the Utilization Review Company, and/or any relevant medical provider(s) and will be utilized solely for the purpose of conducting this external review and may be viewed by an auditor of the Insurance Department for quality surveillance and examination of record purposes. I understand that the decision of the external appeal entity is binding and that neither the Commissioner nor the external appeal entity may authorize services in excess of those covered by my health care plan.

_____ _____

Signature of Patient (or Legal Representative)** **Date**

[** Parent (if patient is under 18 years old), Guardian, Conservator, or Other – Please Specify]

WAIVER OF FILING FEE

The $25 fee will be waived for indigent individuals or those who are unable to pay. Refer to table in the External Appeal Consumer Guide to determine if you qualify as indigent.

I hereby certify that I am indigent or that I am not able to pay and request a waiver of the filing fee. I understand that my financial statements may be requested and viewed by an auditor of the Insurance Department.

_____ _____

Signature of Enrollee (or Legal Representative) **Date**

***** PLEASE COMPLETE ALL PAGES OF THIS FORM ***** revised 6/13/2007

April 16, 2009

Dina B. Berlyn, Esq
30 Morris Street
Hamden, CT 06517
Dina.berlyn@coa.ct.gov
dinaberlyn@yahoo.com
w-860-240-8629 c-203-530-2529
work fax 860 240 0208

To: Sonia Suelen 978 741 1990

From: Dina Berlyn

Re: 384170

As we discussed, I would be most appreciative of receiving a copy of the entire record in my case. In addition, I need either the benefits handbook or certificate of coverage.

Thank you.

Dina B Berlyn

Dina B. Berlyn

I did not get these

C Caremark.com

CVS CAREMARK

April 14, 2009

Ms. Dina Berlyn
30 Morris Street
Hamden, CT 06517

Dear Ms. Berlyn:

CVS Caremark manages the prescription drug benefits for employees and dependents of The State of Connecticut.

This letter is in response to your recent request from **April 14, 2009**, for the internal rule, protocol or guideline that was used to determine the benefits regarding the medicine, **Provigil**.

Under the State of Connecticut Prescription Benefit Plan, Provigil is covered with Prior authorization. As such, Provigil is covered for patients who meet the following criteria:

- Narcolepsy confirmed by polysomnography
- Obstructive Sleep Apnea/Hypopnea Syndrome confirmed by polysomnography with respiratory monitoring and
  - the patient is currently utilizing continuous positive airway pressure (CPAP) therapy, or
  - CPAP therapy is contraindicated for the patient, or
  - CPAP therapy was tried and found to be ineffective for the patient even though the patient was compliant with therapy, or
  - the patient has mild obstructive sleep apnea/hypopnea syndrome, the patient uses an oral appliance and the patient is compliant with oral compliance use.
- Shift Work Sleep Disorder (SWSD)
  - The patient experiences sleepiness while working, and
    - The patient works the night shift (at least 5 hours between the hours of 11pm and 7am) permanently, or
    - The patient works the night shift frequently (5 times or more per month).

CVS CAREMARK

Our records show that your physician provided a diagnosis of Multiple Sclerosis related fatigue. This diagnosis does not meet the above criteria.

the prescription was for fatigue not cog dys

In addition, this case was forwarded to an outside medical reviewer for review at the first and second level of appeal. The physician reviewer at the first level of appeal stated "there are no randomized, double-blind, placebo-controlled studies supporting the use of Provigil for cognitive dysfunction in MS. Although Provigil may be of benefit in this patient for the treatment of her fatigue and cognitive dysfunction, it cannot be deemed medically necessary based on current medical literature."

At the second level of appeal, the physician reviewer stated, "the only peer reviewed study in the literature finds Provigil to be of no value for MS fatigue. Therefore, its use for this indication is unproven, investigational and not medically necessary." WRONG. See Rammohan, Zifko, and Large paper

Based on this information, the clinical criteria for coverage of Provigil were not met, and it was not determined to be medically necessary by outside medical review. As a result, the request for coverage was denied.

If you have any further questions or comments about this matter, please contact CVS Caremark's Clinical Services Division toll-free at **1-800-952-9684**.

Sincerely,

Clinical Services
CVS Caremark
Case 384170 / jar

CVS CAREMARK

April 09, 2009

DINA BERLYN
30 MORRIS ST
HAMDEN, CT 06517

Re: DINA BERLYN
Medication: PROVIGIL 100 MG TABLET
Provider: JANA PREININGEROVA, MD
Case Number: 384170

Dear DINA BERLYN:

CVS Caremark reviews the medical necessity of medications for State of Connecticut plan participants.

Our consultant, a board certified Neurologist, has reviewed the clinical information regarding this case. Based on the information provided, the prescription for PROVIGIL 100 MG TABLET has not been approved because:

The requested medication is not covered for the submitted diagnosis of Multiple Sclerosis related fatigue. The physician reviewer has contacted the Prescriber for further information regarding the diagnosis provided for this medication and has denied the request for coverage. The patient does not have an FDA approved indication for the use of Provigil. Therefore, its use for this diagnosis at this time cannot be supported by current medical literature.

All internal appeals have now been exhausted. However, you have the right to file an external appeal with the Insurance Commissioner. If you elect to do so, an appeal must be submitted in writing by you or your doctor, with your written consent, within 60 days of receiving this communication. You may contact the Connecticut Insurance Department by calling (860) 297-3910 or by writing to:

Connecticut Insurance Department
P.O. Box 816
Hartford, CT 06142-0816
Attn: External Appeals

Please note: The external appeals process is not available to enrollees who are covered under a non-governmental self-insured plan established pursuant to the Employee Retirement Income Security Act of 1974 (ERISA) or to denials regarding workers compensation.

External appeals will be determined within 30 business days of completing the preliminary review, at which time you will be notified.

You may request the applicable criteria, if any, used in this case by contacting CVS Caremark's Clinical Prior Authorization Department. If you have any questions or would like to talk with a Clinical Prior Authorization Representative, please call toll-free 1-800-952-9684.

Sincerely,

Clinical Services
CVS Caremark

cc: JANA PREININGEROVA, MD

Enclosures: External Appeal Consumer Guide, External Appeal Request Form

CVS CAREMARK

April 03, 2009

DINA BERLYN
30 MORRIS ST
HAMDEN, CT 06517

Re: DINA BERLYN
Medication: PROVIGIL 100 MG TABLET
Provider: JANA PREININGEROVA, MD
Case Number: 384170

It was NOT Prescribed for Cognitive Dysfunction! It is for fatigue. Cognitive Dysfunction is NOT mentioned in my medical records at all!

Dear DINA BERLYN:

CVS Caremark reviews the medical necessity of medications for State of Connecticut plan participants.

Our consultant, a licensed physician, has again reviewed the clinical information regarding this case. Based on the information provided, the prescription for PROVIGIL 100 MG TABLET has not been approved because:

The requested medication is not covered for the submitted diagnosis of Multiple Sclerosis related fatigue. The physician reviewer has contacted the Prescriber for further information regarding the diagnosis provided for this medication and has denied the request for coverage. The patient does not have an FDA approved indication for the use of Provigil. There are no randomized, double-blind, placebo-controlled studies supporting the use of Provigil for cognitive dysfunction in MS. Therefore, its use for this diagnosis at this time cannot be supported by current medical literature.

Not prescribed for Cog dys!

You have the right to request another appeal. If you elect to do so, an appeal should be submitted in writing by you or your authorized representative within 180 days of receiving this communication. The appeal should identify any issues, comments or additional evidence to support your request and should include your medical record as it relates to this request.

For cases of an urgent nature, you may request an expedited appeal by calling 1-800-952-9684, faxing a written appeal to 1-800-230-0783 or mailing a written appeal with a copy of this letter to:

CVS Caremark Clinical Services
Clinical PA Department
P.O. Box 519
Lincoln, RI 02865

You may submit an appeal for any denial or limitation of a requested service by calling the Clinical Prior Authorization Department toll-free at 1-800-952-9684. You have the right to be represented by a person of your choice and can indicate this choice either verbally or in writing when starting the appeals process. Appeals are determined within 15 days of receipt of the request. An expedited appeal may be requested when a service is urgent in nature, and will be completed within 24 hours of receipt of all necessary information.

Once all internal appeals have been exhausted, you have the right to file an external appeal with the Insurance Commissioner. If you elect to do so, an appeal must be submitted in writing by you or your doctor, with your written consent, within 60 days of the final denial notice. You may contact the Connecticut Insurance Department by calling (860) 297-3910 or by writing to:

Connecticut Insurance Department
P.O. Box 816
Hartford, CT 06142-0816
Attn: External Appeals

Please note: The external appeals process is not available to enrollees who are covered under a non-governmental self-insured plan established pursuant to the Employee Retirement Income Security Act of 1974 (ERISA) or to denials regarding workers compensation.

You may request the applicable criteria, if any, used in this case by contacting CVS Caremark's Clinical Prior Authorization Department. If you have any questions or would like to talk with a Clinical Prior Authorization Representative, please call toll-free 1-800-952-9684.

Sincerely,

Clinical Services
CVS Caremark

cc: JANA PREININGEROVA, MD

Yale University School of Medicine
Department of Neurology
40 Temple St 6C
New Haven, Connecticut 06510
203-785-4085
FAX: 203-785-4937

March 26, 2009

Re: Dina ~~Berlyn~~ Berlyn

DOB: 1/21/66

To Whom It May Concern:

This is an appeal for re-consideration of your denial of coverage of modafi nil (Provigil) for my patient Dina Berlyn who has a diagnosis of relapsing-remitting multiple sclerosis. I write as both Ms. Beryln neurologist and as a specialist in the management of multiple sclerosis.

Fatigue is recognized by the National Multiple Sclerosis Society (NMSS) as the most common symptom of the disease, and is known to affect over three-fourths of all those living with MS. The diagnosis and management of MS-related fatigue is described in the Society's Clinical Bulletin "Management of Fatigue in Multiple Sclerosis", which is enclosed for your information. In a 2002 study to assess the efficacy and safety of modafinil for the treatment of fatigue in MS, Rammohan and colleagues found that 200 mg/day of modafinil significantly reduced fatigue and was well tolerated.

A review of Ms. Berlyn's medical history documents history of RRMS diagnosed in early 1997 and report of severe, debilitating fatigue and day time sleepiness dating back more than five years.

I believe continuation of treatment with Provigil is medically necessary and appropriate, and urge you to provide coverage of it as an off-label indication for her MS-related fatigue. If Provigil is discontinued her fatigue may result in preventable disability, inability to live independently or maintain employment, depression, immobility, muscle weakness, etc.)

I hope this information is helpful to you and others, and encourage you to contact me at (203) 785-4085 if I may be of further assistance.

Sincerely,

Jana Preiningerova, MD

Dina B. Berlyn, Esq.
30 Morris Street
Hamden, CT 06517
Dina.berlyn@cga.ct.gov
w-860-240-8629 c-203-530-2529

March 23, 2009

CVS Caremark Clinical Services
Clinical PA Department
P.O. Box 519
Lincoln, RI 02865

Dear Caremark:

This letter is my appeal of your unwarranted decision to deny coverage of Provigil (Modafinil) 100 mg. You have a lot of gall to think that it is ok for you to substitute your judgment for that of my treating physician. My physician, Dr. Jana Preingerova, is an MS specialist who also knows my specific case. MS is a very individualized disease and no two patients are the same; part of treating this disease has to be done by a sort of educated trial and error. Dr. Preiningerova must be allowed to practice medicine and search for the best treatment regimen for each patient free of absurd encumbrances such as unjustified medication denials like this one. Perhaps you are unaware that fatigue is the most common (and quite debilitating) symptom of multiple sclerosis. Provigil is not the first drug that I have taken to fight fatigue but it is the first one that worked (I did not find amantidine helpful).

One of the excuses that I was given for the denial is that there are conflicting reports in the literature. In this situation, the decision must be made by the physician who has knowledge of the specific case. I did a quick literature search myself and found two article supporting the use of Modafinil for MS patients (J. Neurol Neurosurg Psychiatry 2002 Feb;72(2):150 and J Neurol, 2002 Aug;249(8): 983-7). I found one article that did not find benefit but the article noted that the sample size in the study was extremely small (Drugs. 2008; 68(13): 1803-39). In Addition, I believe that a paper was presented at the European Committee for Treatment and Research in Multiple Sclerosis which demonstrated that the combination of Interferon-beta and Modafinil are effective at treating cognitive symptoms of MS.

Provigil has made it possible for me to continue in my job (counsel and executive aide to the majority leader of the state senate). If you intend to deny my access to the drug, do you plan to pay my salary and healthcare benefits? Before I took Provigil I found it nearly impossible to stay awake in the afternoon. Provigil has been a fantastic remedy for me. The only rational decision for you to make is to approve the prior authorization.

I would like to point out that your company has the worst customer service I have ever experienced. I was kept on hold for well over an hour over two days at one point. I know you only have records of me calling beginning March 7; I called earlier but no one would take my name. One of the people I talked to informed me that Caremark is not an insurance company and thus not bound by CT insurance law. That was not a smart statement. Perhaps the state legislature needs to take a look at the best way to regulate PBMs to prevent them from denying needed medication to patients. I was given all kinds of incorrect information by Caremark's customer service and the process was dragged out so long that I had to get samples from my doctor. THE POLICY YOU SHOULD HAVE IS THAT IF YOU ARE GOING TO DENY A PERSON IN THE PRIOR AUTHORIZATION, YOU SHOULD APPROVE ONE MONTH'S SUPPLY TO GET THAT PERSON THROUGH THE APPEALS PROCESS. CONNECTICUT REQUIRES THIS FOR ITS MEDICAID MANAGED CARE ORGANIZATIONS! In my case, because I screamed like a stuck pig to the Comptroller's office, I did get a call from Caremark and the denial was overridden for one month. But this should be your standard policy – not just special treatment for me because of who I know and where I work!!!

I honestly hope that you not only reverse your denial on appeal but also change your galling policies in which you inappropriately substitute your judgment for that of the treating physician. If you deny this appeal please realize that I will also pursue an external appeal with the Office of the Healthcare Advocate. That office is also well aware of your poor customer service.

I assume that none of you in the denial business have any family members who suffer from chronic incurable ailments. If you did you would not make decisions such as this one.

Thank you.

Dina Berlyn, Esq.

Addendum:

Because Caremark is performing a government function, I believe it must follow government rules in regard to transparency. Please forward to me:
% of state employee claims that are denied
% of state employee claims for Provigil that are denied
$ Caremark receives from pharmaceutical companies that make Provigil competitors

→ then did not send this in

CVS CAREMARK

March 16, 2009

DINA BERLYN
30 MORRIS ST
HAMDEN, CT 06517

Re: DINA BERLYN
Medication: PROVIGIL 100 MG TABLET
Provider: JANA PREININGEROVA, MD
Case Number: 384170

Dear DINA BERLYN:

CVS Caremark reviews the medical necessity of medications for State of Connecticut plan participants. After careful review of the information provided, it has been determined that the request for PROVIGIL 100 MG TABLET does not meet medical necessity criteria because:

The requested medication is not covered for the submitted diagnosis of Multiple Sclerosis.

You have the right to appeal this decision. If you elect to do so, an appeal should be submitted in writing by you or your authorized representative within 180 days of receiving this communication. The appeal should identify any issues, comments or additional evidence to support your request and should include your medical record as it relates to this request.

For urgent cases, you may request an expedited appeal by calling toll-free 1-800-952-9684, faxing a written appeal to 1-800-230-0783 or mailing a written appeal with a copy of this letter to:

CVS Caremark Clinical Services
Clinical PA Department
P.O. Box 519
Lincoln, RI 02865

I would like to point out that your company has the worst customer service I have ever experienced. I was kept on hold for well over an hour over two days at one point. I know you only have records of me calling beginning March 7; I called earlier but no one would take my name. One of the people I talked to informed me that Caremark is not an insurance company and thus not bound by CT insurance law. That was not a smart statement. Perhaps the state legislature needs to take a look at the best way to regulate PBMs to prevent them from denying needed medication to patients. I was given all kinds of incorrect information by Caremark's customer service and the process was dragged out so long that I had to get samples from my doctor. THE POLICY YOU SHOULD HAVE IS THAT IF YOU ARE GOING TO DENY A PERSON IN THE PRIOR AUTHORIZATION, YOU SHOULD APPROVE ONE MONTH'S SUPPLY TO GET THAT PERSON THROUGH THE APPEALS PROCESS. CONNECTICUT REQUIRES THIS FOR ITS MEDICAID MANAGED CARE ORGANIZATIONS! In my case, because I screamed like a stuck pig to the Comptroller's office, I did get a call from Caremark and the denial was overridden for one month. But this should be your standard policy – not just special treatment for me because of who I know and where I work!!!

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I assume that none of you in the denial business have any family members who suffer from chronic incurable ailments. If you did you would not make decisions such as this one.

Thank you.

Dina Berlyn, Esq.

Addendum:

Because Caremark is performing a government function, I believe it must follow government rules in regard to transparency. Please forward to me:
% of state employee claims that are denied
% of state employee claims for Provigil that are denied
$ Caremark receives from pharmaceutical companies that make Provigil competitors

→ then did not send this in

You may submit an appeal for any denial or limitation of a requested service by calling CVS Caremark's Clinical Prior Authorization Department toll-free at 1-800-952-9684. You have the right to be represented by a person of your choice and can indicate this choice either verbally or in writing when starting the appeals process. Appeals are determined within 15 days of receipt of the request. An expedited appeal may be requested when a service is urgent in nature, and will be completed within 24 hours of receipt of all necessary information.

Once internal appeals have been exhausted, you have the right to file an external appeal with the Insurance Commissioner. If you choose to do so, an appeal must be submitted in writing by you or your doctor, with your written consent, within 60 days of the final denial notice. You may contact the Connecticut Insurance Department by calling (860) 297-3910 or by writing to:

Connecticut Insurance Department
P.O. Box 816
Hartford, CT 06142-0816
Attn: External Appeals

Please note: The external appeals process is not available to enrollees who are covered under a non-governmental self-insured plan established pursuant to the Employee Retirement Income Security Act of 1974 (ERISA) or to denials regarding workers compensation.

You may request the applicable criteria, if any, used in this case by contacting CVS Caremark's Clinical Prior Authorization Department. If you have any questions or would like to talk with a Clinical Prior Authorization Representative, please call toll-free 1-800-952-9684.

Sincerely,

Clinical Services
CVS Caremark

cc: JANA PREININGEROVA, MD

Quality is Our Bottom Line

19/6

Insurance Committee Public Hearing

Thursday, March 15, 2012

Connecticut Association of Health Plans

Testimony in Opposition to

SB 410 AAC Adverse Determination Reviews

The Connecticut Association of Health Plans respectfully urges the committee's rejection of SB 410 AAC Adverse Determination Reviews. Connecticut has already taken significant action in the area of adverse determinations, and in fact, our external appeal process is held up as a model around the country. 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 additional requirements proposed under SB 410 require that carriers provide free of charge with every notice of appeal and upheld adverse determination a copy of all documents, communications information and rationale regarding the adverse determination ***regardless of whether the member requests such information and regardless of whether such information was even considered by the health plan in making such determination*** Current law already requires that a covered person may receive from a carrier, free of charge and upon request, reasonable access to copies of all documents, records and other information relevant to the adverse determination under review. We would strongly argue that this provision does nothing, but raise administrative costs significantly when premium price sensitivity is particularly high.

SB 410 further requires that upon a denial and subsequent appeal for prescription drugs that health plans be required to provide immediate electronic authorization and payment to the covered person's pharmacy for such drug for the duration of any such grievance or review. Consider the implications for safety if, in fact, this provision were implemented relative to controlled substances. A person would be guaranteed access to, and payment for, oxycontin provided they presented with a script. The same would be true if a drug were denied because of a potential drug interaction or other clinical reason. Coverage for drugs considered to be experimental would also be required if this bill would pass. Not only would this provision add enormous cost to pharmacy benefits that may cause employers to drop coverage all together, but it would also give rise to serious safety considerations.

We strongly urge your rejection of SB 410. Thank you for your consideration.

280 Trumbull Street | 27th Floor | Hartford, CT 06103-3597 | 860 275 8372 | Fax 860 541 4923 | www ctahp com

20/1

Testimony of Victoria Veltri
State Healthcare Advocate
Before the Insurance and Real Estate Committee
In Re SB 410
March 15, 2012

Good afternoon, Representative Megna, Senator Crisco, Senator Kelly, Representative Sampson, and members of the Insurance and Real Estate Committee. For the record, I am Vicki Veltri, State Healthcare Advocate 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.

I would like to express support for the consumer protections promoted by SB 410. This bill establishes equity in the process by requiring that health insurance carriers automatically provide consumers with all documents, communications, information, evidence and rationale regarding an adverse determination. Given the statutory deadlines that consumers must meet in order to appeal an adverse determination, SB 410 eliminates substantial barriers that consumers currently face when attempting to reconstruct the carrier's justification for the denial of coverage and identify any errors or deficiencies in said rationale. With this reform, consumers will no longer have to

phone 860 297 3980 toll free 1 866 466 4446 fax 860 297 3992
po box 1543 hartford, ct 06144
web ct gov/oha
NOW YOU'LL BE HEARD

request the information and hope that the information they receive is complete. Instead, by requiring the carrier to provide this information with the adverse determination, consumers are empowered to more effectively challenge adverse determinations that they believe are unjustified. The filing of an appeal of denial of benefits is comparable to any other case. A consumer is entitled to the information necessary to make a complete record of his or her case in order to wage the most effective appeal possible.

With the passage of P.A. 11-158, carriers were required to make clinical rationale available to consumers prior to a final adverse decision in order to give time for a consumer to respond to that rationale. At least one carrier repeatedly failed to provide this additional information after conducting appeals with a peer reviewer present at the appeals. Consumers were not provided the clinical rationale used by the peer reviewers in their discussions with the appeal panels. This failure to provide information would be corrected by SB 410.

Insurers use criteria to make utilization review determinations. Those criteria may be outdated or reference literature that is outdated. SB 410 would provide consumers with the opportunity to access literature cited by carriers in their denials, but not currently available to consumers.

The additional protections offered in SB 410 do not conflict with federal regulations governing the internal and external grievance processes. Those processes are set as the floor, while Connecticut can offer additional protections to consumers.

Section 1(h) of this bill promotes equity by eliminating barriers to essential care as determined by the consumer's treating physician. The inclusion of a requirement that carriers authorize coverage for prescriptions for the duration of an appeal or review

guarantees that Connecticut's citizens will has access to treatment that their physician has identified as appropriate, avoiding potentially serious consequences that may result from delaying the onset of treatment. The provision of a temporary supply of medications has long been standard practice in the Medicaid program, and did not resulted in complaints by the managed care entities that provided services to Medicaid recipients prior to the current ASO structure. We should allow this temporary supply in our commercial plans as a matter of good public policy and consistency in our programs. The temporary supply does not prevent the insurers from imposing utilization review.

In fact, the 2011 Consumer Report Card issued by the Insurance Department for carrier activity during 2011 demonstrated that between 21 and 66% of claims denied following utilization review were overturned and ultimately authorized on appeal. Given that an average of 42% of appealed denials were found to be incorrect, it is appropriate to err on the side of the treating physician and the consumer throughout the appeal or review process.

Thank you for providing me the opportunity to deliver OHA's testimony today. If you have any questions concerning my testimony, please feel free to contact me at victoria.veltri@ct.gov.

phone 860 297 3980 **toll free** 1 866 466 4446 **fax** 860 297 3992
po box 1543 hartford, ct 06144
web ct gov/oha
NOW YOU'LL BE HEARD

SENATOR MARTIN M. LOONEY
MAJORITY LEADER

Eleventh District
New Haven & Hamden

State of Connecticut
SENATE

State Capitol
Hartford, Connecticut 06106-1591
132 Fort Hale Road
New Haven, Connecticut 06512
Home. 203-468-8829
Capitol 860-240-8600
Toll-free· 1-800-842-1420
www SenatorLooney.cga ct.gov

2/1

March 15, 2012

Good afternoon Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee. I am here to testify in support of SB 410, AN ACT CONCERNING ADVERSE DETERMINATION REVIEWS.

SB 410, would create greater equity for patients who are denied services from managed care organizations, health insurers, or utilization review companies ("insurers") by allowing patients access to the complete record in the case. This is a simple matter of fairness since 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, drug, or device is medically necessary. In general, the burden of proof in any case should be placed on the party who has the information. Here, that party is the insurer which is the only party with knowledge as to why a claim was denied.

Ideally, the burden of proof should be switched to create an assumption that medical treatments, drugs, and devices that are ordered by a licensed provider are medically necessary and thus place the burden of proof in its rightful

place- on the insurer that is denying coverage. However, since this change is unlikely, at least we must allow the patients and providers the information they need to appropriately file an appeal. Insurers are not always forthcoming with the records 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 and thus allow the patient and provider to make the appropriate arguments on appeal.

While requirements in the federal health reform bill (and the conforming changes in PA 11-58) grant access to certain documents used by the insurers, it did not require that the patient be provided with all the documents in the case. PA 11-58 does meet the minimum requirements contained in the Patient Protection and Affordable Care Act. These requirements are, however, a floor not a ceiling; states are free to offer additional patient protections and we should.

This bill would require that the insurer provide all the information to the patient and provider; the patient and provider should not be left guessing as to the reasons for denial. This legislation would allow them a fair chance to present the counter-argument with access to all the appropriate information; it is simply a matter of fairness and equity. If the patient has the burden of proof, the patient

must be given ALL of the available information. Any other arrangement is untenable.

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.

I have experienced denials which were presented in a less than clear manner. In one of these, it turned out that somehow the pharmacy benefits manager had somehow erroneously transcribed my date of birth. Even just straightening out this seemingly simple matter took a good amount of time and a number of phone calls. The reason for the denials was not initially made clear to me, and I have skills and resources that many of our constituents do not. I know of others, including Dina Berlyn in my office, who have faced even more complicated appeals and have not been able to acquire the complete records in their cases. This bill would do much to level the playing field on the issue of adverse determination reviews.

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

FTR

Advocacy for Patients with Chronic Illness, Inc.

195 Farmington Avenue
Suite 306
Farmington, CT 06032
(860) 674-1370 (phone)
(860) 404-5127 (fax)
www.advocacyforpatients.org
patient_advocate@sbcglobal.net

Testimony of Advocacy for Patients with Chronic Illness In Support of Bill Nos. 5486, 5485 and 410

HB5450

March 12, 2012

Thank you for this opportunity to present comments on Bill Nos. 5486, 5485, and 410.

Advocacy for Patients with Chronic Illness is a 501(c)(3) tax exempt nonprofit that provides free insurance and legal assistance to patients with chronic illnesses nationwide. We provide these comments based on our extensive expertise working with chronically ill consumers whose care depends in large part on insurance coverage – the one thread that runs through all three of these Bills.

Raised Bill No. 5486 would limit prescription drug coinsurance to $1000 per year for individuals and $2000 per year for families. This legislation is an appropriate response to the advent of so-called specialty tiers, pursuant to which insurers charge a percentage copay for prescription drugs used to treat chronic conditions such as Crohn's disease, rheumatoid arthritis, and multiple sclerosis. These drugs may cost thousands of dollars per month. For example, we worked with one multiple sclerosis patient whose coinsurance would have been $3000 per month or $36,000 per year – clearly more than most people can afford. Specialty tiers threaten to restrict the best health care to only the very wealthy among us. Raised Bill No. 5486 would ensure that all insured consumers have access to medically necessary care.

These are not newfangled treatments with a lot of bells and whistles; these are mainstream treatments that are used routinely to treat chronic illnesses. For example, Humira, an injectable biologic, has been FDA approved for the treatment of rheumatoid arthritis since 2003, and for the treatment of Crohn's disease since 2007. It has become standard therapy for these indications. We have worked with literally hundreds of patients whose diseases have remitted due to the use of this medication, and its continued use helps to maintain remission. Although it is expensive, without it, a patient with Crohn's disease could experience a flare that could lead to a hospitalization, surgery, a feeding tube – all of which would be far more expensive than enabling patients to access this drug with an affordable copay.

Indeed, it is our view that insurers who utilize specialty tiers are extremely short-sighted. If a patient with a serious chronic illness has found something that puts and keeps their illness in remission, their health care costs will be far lower than they would be if their

Finally, SB 410 makes two very important additions to the statutes governing the conduct of insurance appeals. First, it requires insurers to include copies of all documents, communications, information, evidence and rationale with notices of adverse determinations. This would make a world of difference to consumers who wish to challenge adverse determinations. Indeed, it would help consumers to understand the basis for adverse determinations so that they could decide whether or not to raise such a challenge.

In addition, this provision would eliminate the problems that have always arisen under the existing statutory language, which allows consumers to request these materials if they so choose. In our very considerable experience representing consumers in health insurance appeals, insurers typically ignore such requests. Even worse, we have had the vexing experience of having this request for documents counted as an appeal, thereby depriving the patient of an entire level of review. If consumers are to be better able to evaluate and challenge adverse determinations, this statutory change should be passed.

In addition, SB 410 provides that, when an insurer denies coverage of a prescription drug and the consumer appeals, the insurer must authorize coverage of the drug during the pendency of the appeal. Not only would this provision encourage insurers to process appeals on a timely basis, but it will ensure that consumers have access to medically necessary care in the interim. Essentially, this provision creates a temporary presumption in favor of the treating physician's judgment in prescribing the medication. We urge its passage.

In sum, we strongly urge the passage of Bill No. 5486 and SB 410, but strongly oppose Bill No. 5485 as it pertains to the Basic Health Program, and urge the Committee to task the Health Insurance Exchange Board, in consultation with all stakeholders, to study and make a recommendation to this Committee regarding the choice of a benchmark plan to serve as the Essential Health Benefits package – one of the most important decisions the State will make in implementing the ACA.

Thank you.

S - 642

CONNECTICUT GENERAL ASSEMBLY SENATE

PROCEEDINGS 2012

VOL. 55
PART 7
1961 – 2275

incorporated by reference into the Senate Journal and the Senate Transcript.

THE CHAIR:

Seeing and hearing no objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President. Mr. President, if we might stand at ease for just a, oh, I believe we're ready to recall the item that was previously passed temporarily and that was Calendar Page 5, Calendar 225, Senate Bill Number 410 AN ACT CONCERNING ADVERSE DETERMINATION REVIEWS.

THE CHAIR:

Thank you, Senator. Mr. Clerk.

THE CLERK:

On Page 5, Calendar 225, Substitute for Senate Bill Number 410 AN ACT CONCERNING ADVERSE DETERMINATION REVIEWS. Favorable Report of the Committee on Insurance and Real Estate.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Yes. Again, let me move for acceptance of the Joint Committee's Favorable Report and passage of the bill.

THE CHAIR:

On acceptance and passage. Will you remark, sir?

SENATOR CRISCO:

Yes. The Clerk has an amendment, LCO 4138. I ask that it be called and I be given permission to summarize.

THE CHAIR:

Mr. Clerk, please call LCO 4138.

THE CLERK:

LCO Number 4138, Senate "A", offered by Senators Crisco, Fasano, Kelly and Representative Megna.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you. This bill --

THE CHAIR:

Move adoption, please.

SENATOR CRISCO:

I move adoption.

THE CHAIR:

On adoption, will you remark, sir?

SENATOR CRISCO:

We consider an enhanced patient bill of rights. It gives patients upon request access information from the insurer during the appeals process.

The bill will create greater equity for patients who choose to appeal when they are denied services by their health carriers.

It allows patients access to the complete record in a case, which will allow patients to present a better appeal and to still have a better chance of success.

The information that will be available upon request includes all documents, communications, information and evidence, including citations to journal articles used in decisions.

This is a very simple matter of fairness, since the patients' providers have the burden of proof, they should have the information if they request it.

While the Federal Healthcare Reform Bill guarantees patients' access to some records during the appeals process, it does not, it does not require access to the complete record. This bill will require that the patient get all the information that the insurer has.

The federal bill, members of the circle, is a floor and not a ceiling and the states are free to offer additional protections to patients.

Even with the protections in the Federal Reform Healthcare Act, insurers are not always forthcoming with the records in the case. Access to the records would offer the patient and the provider critical information as to how the decision to deny coverage was formulated and thus allow the patient and provider to make the appropriate arguments on appeal.

THE CHAIR:

Thank you, Senator. Will you remark further on the amendment? Senator Kelly.

SENATOR KELLY:

Thank you, Mr. President. I rise in support of the amendment. I think what we have before us is common sense.

As Senator Crisco pointed out, what we're doing is empowering the patient with the information that was critical to the decision and giving them the ability to review that information and with the burden of proof, to defend themselves and the actions that they think are appropriate.

What this bill does is, or the amendment does is, if the person asks for that, the information will be provided free of charge. And as I said, this is common sense and you would hope that this is what the current practice is, but unfortunately it's not.

And here this bill will make it the practice. I think it enhances the bill and I stand in full support of this measure. Thank you, Mr. President.

THE CHAIR:

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

SENATOR FASANO:

Thank you, Mr. President. Mr. President, I stand in support of the amendment. Thank you.

THE CHAIR:

Thank you, Senator. Senator Looney.

SENATOR LOONEY:

Thank you, Mr. President. Speaking in support of this bipartisan amendment, wanted to thank Senator Crisco for all of his work on this issue and the Insurance and Real Estate Committee because it is as Senator Kelly pointed out, a common sense response.

Because, we know in many cases that patients who may be denied services from managed care organizations, health insurers or utilization review companies, have difficulty sometimes determining what is the basis upon which the denial was predicated.

So this amendment, this bill as amended will allow patients' access to the complete record in the case upon the patient's request. It's a simple matter of fairness since one of these entities will deny coverage, it is difficult without knowing the full basis and the information used for that denial so that the patient and the patient's provider may have a chance to make the case in rebuttal of that denial.

So therefore, it is critical that that full file be provided to the patient and the patient's healthcare provider upon request, and that's what this will, what will provide, that the information that will be available upon request includes all documents, communications, information and evidence, including

citations to journal articles used in the decision and allows patients access to the complete record, which will allow them to frame a more comprehensive appeal of the denial of healthcare.

It's a matter of fairness since the patients and providers have the burden of proof to overturn the denial, they should have all of the information at hand to contest that denial if they request it.

And while the Federal Healthcare Reform Bill does guarantee patients access to some records during the appeals process, it does not guarantee access to the complete record and this bill would require that. So the federal bill, as Senator Crisco said is a floor and not a ceiling and states are free to offer additional protections to patients, which this will do.

So I believe that it's important as a matter of fairness and access to adopt this amendment. Thank you, Mr. President.

THE CHAIR:

Thank you, Senator Looney. Will you remark further on the amendment? If not, I'll try your minds. All those in favor please signify by saying Aye.

SENATORS:

Aye.

THE CHAIR:

Opposed, Nay? The Ayes have it. The amendment is adopted. Senator Crisco.

SENATOR CRISCO:

Yes, sir. I think this is an extreme example of what can be accomplished for the people of Connecticut when both sides of the aisle work together on the issue and I'm equally appreciative to my Ranking Member, Senator Kelly and Senator Fasano and Senator Looney and his staff, for all the work that was done and also with the insurance companies and insurance providers to get

it right and again, achieve a hallmark of legislation for the people of Connecticut.

And if there's no objection, I ask that it be placed on the Consent Calendar.

THE CHAIR:

Thank you, Senator. So ordered. Senator Looney.

SENATOR LOONEY:

Thank you, Mr. President. Mr. President, if we might take a brief recess, I hope that we will be ready to begin on an item that had earlier been marked item of the day upon our reconvening. So I would just ask for a brief recess. Thank you, Mr. President.

THE CHAIR:

Thank you, Senator.

On motion of Senator Looney of the 11th, the Senate at 4:35 p.m. recessed.

The Senate reconvened at 4:45 p.m., Senator of the 11th, the President in the Chair.

THE CHAIR:

The Senate will come back to order. Senator Looney.

SENATOR LOONEY:

Thank you, Madam President. Madam President, have a couple more items to mark before calling for a vote on the Consent Calendar and then moving on to an item that was marked earlier as order of the day.

Madam President, first on Calendar Page 11, Calendar 332, Senate Bill 341. Madam President, would move to place that item on the Consent Calendar.

THE CHAIR:

So ordered, sir.

On Page 29, Calendar 138, Senate Bill Number 27.

Page 26, Calendar 88, Senate Bill 55.

On Page 34, Calendar 311, Senate Bill 101.

On Page 9, Calendar 321, Senate Bill 414.

On Page 1, Calendar Number 63, Senate Bill 227.

On Page 5, Calendar 225, Senate Bill 410.

And on Page 11, Calendar 332, Senate Bill 341.

THE CHAIR:

Senator Looney.

SENATOR LOONEY:

Yes, Madam President, if we might wait just a moment. We needed to verify a couple of items before the Consent Calendar is voted.

THE CHAIR:

Absolutely, sir.

THE CLERK:

And there is one more item. On Page 33, Calendar 295, Senate Bill Number 248.

THE CHAIR:

Are any other additions or corrections that we can see? If not, then Mr. Clerk, will you please call for a roll call vote and the machine will be opened on the Consent Calendar.

THE CLERK:

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

THE CHAIR:

Have all members voted? If all members voted the machine will be locked. Mr. Clerk, will you please call the tally on the Consent Calendar.

THE CLERK:
On today's Consent Calendar.

Total number voting	35
Necessary for passage	18
Those voting Yea	35
Those voting Nay	0
Those absent and not voting	1

THE CHAIR:

The Consent Calendar passes.

Right now I ask for points of personal privilege. Senator McKinney.

SENATOR MCKINNEY:

Thank you, Madam President. I rise for a point of personal privilege.

THE CHAIR:

Please proceed, sir.

SENATOR MCKINNEY:

Madam President, on my way up to the Capitol this morning I learned the sad news of the passing of a good friend, Jo McKenzie, who many of us in the circle, especially those of us who belong to the Republican Party, affectionately knew Joe McKenzie as Momma Jo.

I first met Momma Jo in the early 1970s as a young boy. She was always active in the Republican Party. In 1979 she was the first woman ever elected Chairman of the Connecticut Republican Party and for probably 15 years plus, served as Republican National Committee Woman from the State of Connecticut.

She was a wonderful woman, always with a laugh and fun, had an incredible sense of style as you may know.