



**Testimony of Kevin Lembo, State Healthcare Advocate
Before the Public Health Committee, Connecticut General Assembly
In Support of H.B. 5308 and H.B. 6841
February 21, 2007**

Good morning Senator Handley, Representative Sayers, Senator Roraback, Representative Carson, and members of the Public Health Committee. For the record, I am Kevin Lembo and I am the State Healthcare Advocate. I apologize that I am unable to be with you today. I submit this testimony today in support of H.B. 5308 and H.B. 6841.

First, I'd like to commend Representative Widlitz and the entire committee for raising the concept and substance of this legislation. These bills address the need for clarity on several issues that ultimately affect consumer access to healthcare –

- 1) Predictable and consistent reimbursement arrangements and methodologies for providers, including a prohibition against unilateral changes in physicians' contract terms;
- 2) Inclusion of a medical necessity definition in the contract so that physicians have the governing standard of care at hand;
- 3) Auditing of the health insurer's compliance with its contractual obligations; and
- 4) Attention to the issue of "down coding".

These bills grow out of an imbalance of bargaining power between physicians and insurers that has resulted in several large-scale class action suits by physicians against insurers. Leveling the playing field for providers by ensuring their ability to bargain fairly and to enforce their contractual rights is critical to ensuring access to healthcare for consumers. H.B. 5308 and H.B. 6841 promote transparency, fairness and consistency, and recognize provider rights, such as the right to an external review process for claims disputes. New Jersey and New York have passed legislation substantially similar to that proposed in H.B. 5308 and H.B. 6841.

In the healthcare arena, transparency must run both ways. As more insurers post provider "costs" and other information, providers must have access to insurer information so that they can explain and/or refute the insurer's representations. Having that information in the contract is the best method of ensuring that providers and insurers are on the same page when it comes to the most meaningful provisions to both parties.

Consistency is also one of the goals of this bill. Since medical necessity is the standard by which payment for healthcare is measured, we propose that H.B. 6841, Section 1 (b)(5) be modified to include a reference to a state standardized definition of medical necessity. We've attached proposed amended language. We hope that a standardized definition of medical necessity will pass this year, providing more consistency for consumers, providers and insurers.

Lastly, we propose adding an additional section to the committee bill that would limit the timeframe in which an insurer can audit a claim that it has already paid to the time period extending from the date of initial claim submission to the time frame matching that established in the contract in which a provider must submit a timely claim for payment. (We have attached language that would make this an addition to CUIPA.) As an example, if Dr. Smith has one year to file a timely claim under his contract with Insurer X, then Insurer X has one year from the date it receives Dr. Smith's claim to audit the claim -- Insurer X may be required to pay the claim more promptly after submission because of prompt payment requirements. After one year, Insurer X would be precluded from contesting the claim or its payment. This is a fairness issue for both consumers and providers and an overdue change to claims processing requirements. At a certain point, consumers and providers have an expectation that a claim will be finally settled.

Thank you for your attention to this testimony. Please contact me with any questions you have concerning our substantive testimony or proposed modifications to the bills. (Our proposed language is attached.)

Suggested language for the medical necessity reference in Section 1 of Raised Bill 6841:

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2007*) (a) As used in this section: (1) "Contracting health organization" means (A) a managed care organization, as defined in section 38a-478 of the general statutes, or (B) a preferred provider network, as defined in section 38a-479aa of the general statutes; and (2) "physician" means a physician or surgeon, chiropractor, podiatrist, psychologist or optometrist.

(b) Each contract for services to be provided to residents of this state entered into, renewed, amended or modified on or after October 1, 2007, between a contracting health organization and a physician shall include: (1) An explanation of the physician payment methodology, the time periods for physician payments and the information to be relied on to calculate payments and adjustments; (2) a requirement that the contracting health organization provide each participating physician prior to the effective date of the contract a copy of the fee schedule that determines the physician's reimbursement and an explanation of the methodologies used to establish the fee schedule; (3) a prohibition against changing the fee schedule during the contract period; (4) a prohibition against changing nonfee related aspects of the contract without the written approval of the physician; (5) a definition of "medical necessity" developed by the contracting health organization based upon generally accepted standards of medical practice or a state standardized definition of medical necessity, whichever controls; and (6) an independent external review process to resolve disputes concerning physician payments and other contract disputes.

Suggested language for claims processing requirement:

Sec. 38a-816(6) of the general statutes is repealed and the following is substituted in lieu thereof:

(6) Unfair claim settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following: (a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue; (b) failing to acknowledge and act with reasonable promptness upon communications with respect to claims arising under insurance policies; (c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; (d) refusing to pay claims without conducting a reasonable investigation based upon all available information; (e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed; (f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear; (g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds; (h) attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application; (i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured; (j) making claims payments to insureds or beneficiaries not accompanied by statements setting forth the coverage under which the payments are being made; (k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration; (l) delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information; (m) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; (n) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; (o) using as a basis for cash settlement with a first party automobile insurance claimant an amount which is less than the amount which the insurer would pay if repairs were made unless such amount is agreed to by the insured or provided for by the insurance policy; (p) auditing or readjudicating a claim for payment after the time period running from the date of submission of the claim to a date matching the timely claims filing period in the provider's contract with the insurer.