

		<div style="text-align: right; font-size: 2em; font-weight: bold;">958</div>  <p style="text-align: center;">OFFICE OF THE HEALTHCARE ADVOCATE Now you'll be heard.</p>
<p style="text-align: center;">RICHARD BLUMENTHAL ATTORNEY GENERAL State of Connecticut</p>		<p style="text-align: center;">KEVIN LEMBO HEALTHCARE ADVOCATE State of Connecticut</p>

**TESTIMONY OF ATTORNEY GENERAL RICHARD BLUMENTHAL AND  
HEALTHCARE ADVOCATE KEVIN LEMBO  
BEFORE THE INSURANCE AND REAL ESTATE COMMITTEE  
In Support of SB 958, *An Act Concerning Utilization Review***

Good afternoon Senator Crisco, Representative Fontana, Senator Caligiuri, Representative D'Amelio and members of the Insurance and Real Estate committee. We appreciate the opportunity to testify in support of Senate Bill 958, An Act Concerning Utilization Review.

This proposal provides greater consumer protections in the health insurer's statutorily-required internal appeals process for medical treatments or procedures requested by the patient's health care provider but denied as medically unnecessary by the insurer.

The utilization review process should be consistently fair and equitable. Yet, our experience as patient advocates tells a different story. Further, the Insurance Department's 2008 managed care consumer report card confirms that the process needs improvement. A relatively high number -- 16.6% -- of patient appeals were rejected by the internal review process. In addition, experience varied greatly from insurer to insurer from only 5.4% of the requests for utilization review denied for Anthem to 28.6% for HealthNet.

The internal appeals process is critically important to patients because of the time and resource commitment necessary to continue the effort to completion. Of the 53,934 internal appeal rejections in 2008, only 2,225 or 4.1% were appealed to the external appeals process (the final step in the process). It is critical to have an appeals process that guarantees a level of fairness and documentation beyond what's described in current law.

Right now, we have a patchwork of appeals processes among the utilization review (UR) companies hired by the insurers. Depending on the company, some enrollees can choose to appeal in person to a panel, while other cases are referred to an outside provider allowing no meaningful input. Only one UR company records the appeal hearing. Other UR companies offer in-person presentations or telephonic presentations that include UR company employees who do not vote as part of the panel but are allowed to participate in deliberations. This is a very confusing system, with opportunities for abuse built into its complexity.

To create a process which allows enrollees to exercise their rights, we need one that's fair and consistent from beginning to end. The revisions in SB 958 require the UR companies to:

- provide an enrollee and the provider a written notice explaining in detail the insurer's position that a particular service is not medically necessary (*It is impossible to develop an argument for appeal without detailed explanation of the basis for the denial -- citation to criteria is insufficient.*)
- establish enrollees' right to a hearing on appeal.
- provide an enrollee the option of a participatory appeal (which may be held telephonically) before it makes a final decision to deny a claim.
- make the insurer's peer-review practitioner available, at least telephonically, for such hearing.
- record the hearing and provide for transcription of the recording if the matter goes to external appeal.
- look beyond company-specific criteria to evaluate "medical necessity," consistent with the statutory definition;
- waive the consumer filing fee of \$25 for external appeals.

### Why are these changes necessary?

#### Case #1: M's vaccine

In Case 1, the insurer failed to review the individual circumstances required by a full medical necessity review. SB 958 would prevent rote and inappropriate application of clinical criteria and prevent the delay of medically necessary care through appropriate determinations upon initial requests for authorization.

*M, age 5, is a boy with chronic respiratory issues whose lung development is closer to that of a child under two years of age.*

*M's pediatrician and pediatric pulmonologist felt that it was medically necessary for M to be given Synagis, the serial vaccine to combat respiratory syncytial virus (RSV). Synagis is especially recommended for those born prematurely, with respiratory and /or immune compromise, but the insurer's criteria limited coverage of the vaccine to children under the age of two. The plan denied authorization for M's vaccine based on the criteria. On appeal, the testimony of the pulmonologist, and the fact that M's lung development was far less than that of the average two year old, convinced the plan to overturn the denial.*

Case 2:

In Case 2, the UR company did not ensure that a case was reviewed by a provider of the same specialty or subspecialty of the provider requesting the service for the enrollee.

*CD has recurrent stage IV breast cancer. She received extensive radiation treatment ten years ago. Her vital organs could not withstand another round of traditional radiation without threatening her life. Her radiation oncologist suggested a targeted form of radiation therapy, called IMRT, to spare her heart and lungs. The UR company denied this treatment through a review of the case by a medical oncologist who recommended chemotherapy. Only after significant delay and wrangling, and no admission of wrongdoing by the UR company, the case was re-evaluated by a radiation oncologist who supported CD's radiation oncologist's treatment plan, and the denial was overturned.*

Provisions such as those requiring recording of hearings and limiting the number of the UR company's attendees at an appeal to voting members will incent the UR companies to act more consistently and appropriately. The ability to question the peer-reviewer's assumptions and conclusions is vital to a fair process since UR companies rely on peer reviewer determinations. Shifting the cost of external appeals to managed care organizations should also push insurers and UR companies to make the correct decisions.

Consumers should be able to count on an appeal process that does not change from plan to plan. As a state, we should encourage consistency in the appeal process as we do in other sections of the insurance statutes. In many cases, the process determines whether someone can indeed access medically necessary care.

Thank you for you attention. We urge you to support SB 958 so that we can substantially improve the utilization appeal process as soon as possible.