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Connecticut State Medical Society

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

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

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

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

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

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

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

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

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