



Quality is Our Bottom Line

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**Insurance Committee Public Hearing
March 4, 2010
Connecticut Association of Health Plans**

Testimony in Opposition to

SB 258 AAC Appeals of Health Insurance Benefits Denials.

The Connecticut Association of Health Plans respectfully urges the Committee's rejection of SB 258 AAC Appeals of Health Insurance Benefits Denials.

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

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

Further legislation in this area of health care is unnecessary and unwarranted. The external appeal process is a well-recognized effective manner in which to resolve questions around medical necessity. The new process established under SB 258 is enormously cumbersome and virtually unworkable. If enacted, it would be, unquestionably, one of the single most expensive mandates ever passed. Given the consumer protections in place under the State's current external appeal law, we would respectfully submit that the intent of SB 258 - to assure that medical professionals are making final decisions with respect to covered services - is already covered.

Many thanks for your consideration.