



STATE OF CONNECTICUT  
INSURANCE DEPARTMENT

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Testimony of the Connecticut Insurance Department  
Before  
The Insurance and Real Estate Committee

January 25, 2011

Senate Bill No. 16--An Act Concerning Standards for Health Care Provider  
Contracts

The Connecticut Insurance Department offers the following comments on Senate Bill 16 – An Act Concerning Standards for Health Care Provider Contracts. The Department respectfully urges the Committee to proceed cautiously on this bill. It includes a number of complicated and unrelated issues, which all merit independent analysis.

Section 1 of the bill relates to the statutory time period a health insurer, health care center or other entity has to process a complete health insurance claim. The Department supports reducing the time period from 45 days to 15 days for electronic claims. We suggest, however, that the statutory time frame for electronic claims begin with receipt by the insurer, rather than sending by the provider. In addition, the Department does not believe it is necessary to extend the time frame for paper claims from 45 days to 60 days.

Section 2 of the bill is much more problematic for the Department. This section requires the Department to establish procedures related to solicitation of network providers by health insurers, health care centers, and other specified entities and maintenance of provider participation in such networks.

The Department is **opposed** to this provision as we do not currently have the appropriate expertise to regulate this area sufficiently. As you are aware, the Department's expertise is in regulating insurance companies and the policies and group certificates they issue to their policyholders. Historically, we have had little involvement in issues involving provider contracts between Managed Care Organizations (MCOs) and participating providers. **As a result, the Department does not have the expertise, data or staff resources to regulate contracts between MCO's and providers.** As such, it would be impossible for the Department to establish provider network adequacy standards that would apply to rural and urban areas, various types of medical practitioners, including general practitioners, ob/gyn practitioners, various specialists, chiropractors, and other licensed medical practitioners, as well as acceptable travel limits and other factors, over which reasonable people could disagree.

In addition, Section 2 permits standards to further vary by the type of specified health insurance under the different subdivisions (1),(2),(4), 11) and (12) of section 38a-469 of the general statutes. This provision compounds the Department's concerns in so far as we do not have the expertise, data, or staff resources to implement this section. **At a time**

**when state government is encouraged to streamline its processes and to be more efficient, adding this requirement only adds more bureaucracy and cost – not only to state government but to the health care system.**

The Department supports Section 3 of this bill, which requires the entities described in Section 2 to maintain a provider network consistent with the standards established by the National Committee for Quality Assurance.

The Department supports the concept outlined in Section 4 of this bill which makes changes to our utilization review law. However, we would like to offer two cautionary comments.

As a result of the Affordable Care Act, the Department of Health and Human Services (HHS) is examining our current external appeal laws and has indicated that our law does not conform to the newly revised NAIC model. Our external appeal law needs to be amended, in order to avoid a July 1, 2011 “take over” by HHS of our external appeal program. As part of this process, we also need to revise our utilization review law. We strongly recommend no changes in our current utilization review law, such as provided in this section 4, which differ from the NAIC model as this section does.

In addition, the language in Section 4 prohibits a carrier from denying claims if there is detrimental reliance by an insured on a favorable utilization review determination. However, a “hard and fast” rule may not be appropriate in all circumstances. The nature of the utilization review process requires that medical necessity determinations be made in advance of services being provided. The Committee may want to consider that there are circumstances in which such a rule may not be appropriate. For example: between the time of medical review and the date of service, (1) the member may no longer be covered under the plan; (2) the requested service may have reached its benefit limit; or (3) an employer may have changed plans or health insurers triggering a change in benefits. These variables cannot be predicted at the time of medical necessity review. However, based on the language of this bill, the health insurer or health care center would be responsible for payment of the claim in these situations.

The Department believes that Section 5 of this bill harms the consumer. This section provides that participating dentist contracts may not include any provisions requiring a dentist to accept a negotiated rate on a non-covered service. As an example, an insured may go to a participating dentist for treatment and find a specific service (such as an implant or crown) is not covered. The consumer’s expectation, in going in-network, is that he or she will get the benefit of a network rate, not full billed charges.

Thank you for allowing the Department the opportunity to offer comments to this bill. As always, we are available to answer any questions the Committee has.