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March 1, 2011

Statement  
On  
SB 1082 An Act Concerning Utilization Review

Good afternoon Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee, my name is Christine Cappiello and I am the Director of Government Relations for Anthem Blue Cross and Blue Shield in CT. I am here to testify against SB 1082 An Act Concerning Utilization Review.

We are unsure why this legislation is before you today. The utilization review statutes that were passed in 1997 and modified over the years have produced a process that allows for a fair and reasonable appeal process for the member, the treating provider and the insurer.

This legislation upsets the delicate balance that over the years that this law has been in place. It does so by no longer making the distinction between prospective and retrospective determinations within the UR statutes and there is a very distinct difference and that difference is acknowledged in statute. Prospective determinations are services that have not yet been performed. Retrospective determinations are decisions on services that have already been performed. Retrospective decisions are about payment for those services not for services that are waiting to be performed. Pre-service or prospective determinations are determinations that need a quick turnaround decision by the plan because a member is awaiting authorization for the service to be performed. By removing the distinction between the two, it applies the appeals process and that quick turnaround unnecessarily and adds confusion and cost to healthcare. For example, this legislation which seeks to change timeframes to a mere 2 days for decisions to be rendered on retrospective claims makes it virtually impossible for the utilization review company like Anthem Blue Cross and Blue Shield to comply with any degree of thoroughness. We would like to further mention that the current UR statutes are consistent with the federal Department of Labor claims regulation which also makes a distinction between pre-service determinations and post service claim or retrospective claims.

We are also concerned about the definition of medical necessity that is set about in Section 1 (D)(9) because it is contradictory to current statute. Section 38a-482a and 38a-513c already defines medically necessity and that has been quite successful in its application. Again, we are unsure why the Legislature would need to address an issue that has already been addressed.

We would also like to point out that this legislation directly contradicts federal healthcare reform - Patient Protection and Affordable Care Act (PPACA) which has several provisions establishing appeals for both members and physicians and since this legislation does not mirror that legislation it creates a dynamic where members, providers and insurers will be unsure which statute to follow particularly in terms of timeframes, etc. PPACA establishes very clear and comprehensive appeals for self insured and individual members who in some instances are not currently covered under the Connecticut statutes that guide the appeals and grievance process. We ask this committee to seriously take into consideration what PPACA does before making any changes to the utilization review process, appeals and grievances process.

This legislation will simply do nothing but add costs to the healthcare. We strongly urge the committee to reject this legislation.

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