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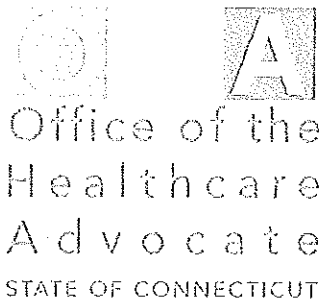

Testimony of Victoria Veltri, Acting State Healthcare Advocate
Before the Insurance and Real Estate Committee
In Support of SB 1082
March 1, 2011

Good afternoon Senator Crisco, Representative Megna, Senator Kelly, Representative Coutu and members of the Insurance and Real Estate Committee. For the record, I am Victoria Veltri, the Acting State Healthcare Advocate. My office, the Office of the Healthcare Advocate (OHA) is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers face in accessing care and proposing solutions to those problems.

Today I testify in support of SB 1082, An Act Concerning Utilization Review. This is a bill that OHA has proposed for the last three years. 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 advocates tells a different story. Further, the Insurance Department's 2010 managed care consumer report card confirms that the process needs improvement. A relatively high number – 15.7% -- of patient appeals were rejected by the internal review process. In addition, experience varied greatly from insurer to insurer from only 4.44% of the requests for utilization review denied for Anthem to 31.0% for CIGNA.

The internal appeals process is critically important to patients because of the time and resource commitment to continue necessary to see the effort to completion. Of the 38,318 internal appeal rejections in 2010, only 1,932 or 5.0% were appealed. It is critical to have an appeal process that guarantees a level of fairness and documentation beyond what's described in current law.

Right now, we have a patchwork of appeal 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 appeals

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 still 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 1082 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 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;

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 1082 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 fact M's lung

development was far less than that of the average two year old, convinced the plan overturned the denial.

Case 2:

In Case 2, the UR company did not ensure that a case is 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, 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 on 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.

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 1082 so that we can substantially improve the utilization appeal process as soon as possible. Please contact me if you have any questions at victoria.veltri@ct.gov or (860) 297-3982.