



Office of the
Healthcare
Advocate
STATE OF CONNECTICUT

**Testimony of Victoria Veltri
State Healthcare Advocate
Before the Insurance and Real Estate Committee
In Re SB 410
March 15, 2012**

Good afternoon, Representative Megna, Senator Crisco, Senator Kelly, Representative Sampson, and members of the Insurance and Real Estate Committee. For the record, I am Vicki Veltri, State Healthcare Advocate with the Office Healthcare Advocate ("OHA"). 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 are facing in accessing care and proposing solutions to those problems.

I would like to express support for the consumer protections promoted by SB 410. This bill establishes equity in the process by requiring that health insurance carriers automatically provide consumers with all documents, communications, information, evidence and rationale regarding an adverse determination. Given the statutory deadlines that consumers must meet in order to appeal an adverse determination, SB 410 eliminates substantial barriers that consumers currently face when attempting to reconstruct the carrier's justification for the denial of coverage and identify any errors or deficiencies in said rationale. With this reform, consumers will no longer have to

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request the information and hope that the information they receive is complete. Instead, by requiring the carrier to provide this information with the adverse determination, consumers are empowered to more effectively challenge adverse determinations that they believe are unjustified. The filing of an appeal of denial of benefits is comparable to any other case. A consumer is entitled to the information necessary to make a complete record of his or her case in order to wage the most effective appeal possible.

With the passage of P.A. 11-158, carriers were required to make clinical rationale available to consumers prior to a final adverse decision in order to give time for a consumer to respond to that rationale. At least one carrier repeatedly failed to provide this additional information after conducting appeals with a peer reviewer present at the appeals. Consumers were not provided the clinical rationale used by the peer reviewers in their discussions with the appeal panels. This failure to provide information would be corrected by SB 410.

Insurers use criteria to make utilization review determinations. Those criteria may be outdated or reference literature that is outdated. SB 410 would provide consumers with the opportunity to access literature cited by carriers in their denials, but not currently available to consumers.

The additional protections offered in SB 410 do not conflict with federal regulations governing the internal and external grievance processes. Those processes are set as the floor, while Connecticut can offer additional protections to consumers.

Section 1(h) of this bill promotes equity by eliminating barriers to essential care as determined by the consumer's treating physician. The inclusion of a requirement that carriers authorize coverage for prescriptions for the duration of an appeal or review

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guarantees that Connecticut's citizens will have access to treatment that their physician has identified as appropriate, avoiding potentially serious consequences that may result from delaying the onset of treatment. The provision of a temporary supply of medications has long been standard practice in the Medicaid program, and did not result in complaints by the managed care entities that provided services to Medicaid recipients prior to the current ASO structure. We should allow this temporary supply in our commercial plans as a matter of good public policy and consistency in our programs. The temporary supply does not prevent the insurers from imposing utilization review.

In fact, the 2011 Consumer Report Card issued by the Insurance Department for carrier activity during 2011 demonstrated that between 21 and 66% of claims denied following utilization review were overturned and ultimately authorized on appeal. Given that an average of 42% of appealed denials were found to be incorrect, it is appropriate to err on the side of the treating physician and the consumer throughout the appeal or review process.

Thank you for providing me the opportunity to deliver OHA's testimony today. If you have any questions concerning my testimony, please feel free to contact me at victoria.veltri@ct.gov.

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